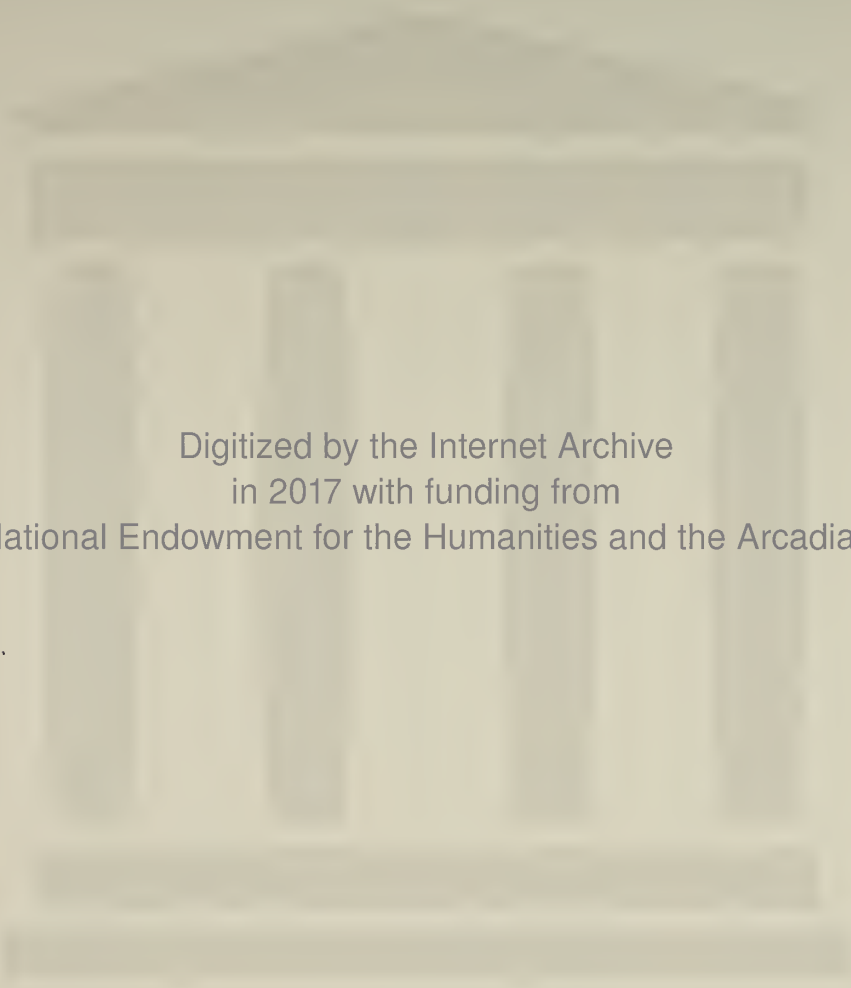


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Ohio Medicine

The Ohio State Medical Association

PIE rehab shocks midwest

The December announcement by the Ohio Department of Insurance (ODI) that it was placing the PIE Mutual Insurance Company into rehabilitation caught many by surprise. It has caused grave concern among current and previous PIE insureds as to the status of their coverage.

The ODI is on PIE premises and has 90 days (from Dec. 15) to determine if the company has enough assets to cover current and future liabilities that will exist as of mid-November when they stopped selling policies and, instead, became an agency for The Doctors' Company (TDC) of California. Jack C. Cummings, senior vice president at TDC has pledged to offer TDC insurance to every PIE insured. They will re-evaluate the physician's current premium, claims history and perform underwriting to TDC's standards. Depending upon the outcome of that review, TDC may increase the proposed policy's premium. PIE is still liable for claims made against its policies. These claims would be paid from PIE's reserves. Physicians can also obtain quotes and policies from other professional liability insurers selling in Ohio.

There is growing evidence that PIE may be under-reserved. ODI has submitted information to the courts that PIE executives may have falsified filings to ODI and misrepresented both cash reserves and the value of current and future assets and liabilities. It is the unknown financial condition of PIE that concerns both regulators and physicians. If PIE is found to be under-reserved, a state

continued on page 3

Tort-reform law goes to Supreme Court

Trial lawyers and labor are using the momentum gained from their victory with Issue 2 and are now attempting to have the tort-reform law overturned.

Ohio's year-old tort-reform law will be tested in court. Trial lawyers and the Ohio AFL-CIO are asking the Ohio Supreme Court to declare the law unconstitutional. Their reasons are as follows:

- Legislators overstepped their legislative authority and exercised judicial power when they changed the rules of evidence.
- The bill that passed (House Bill 350) included more than one subject. The Ohio Constitution forbids multiple subjects in one bill.
- The right to trial by jury is restricted by the provision limiting damage awards.

- The Ohio Constitution prohibits limits in wrongful death awards.

"This challenge is the result of momentum the trial lawyers and big labor experienced on Issue 2 (the referendum repealing the Workers' Compensation reform law)," says Tim Maglione, director, OSMA Department of Legislation and co-chair of the Alliance for Civil Justice, the coalition that supported the tort-reform law. "We knew the trial lawyers would take this case to the courts, and we believed that if big labor and the trial attorneys were victorious on Issue 2, they would partner on other significant issues like tort reform."

The Alliance for Civil Justice has implemented a Court Watch program to monitor any suit that has been filed against the tort-reform law. Maglione says the Alliance for Civil Justice is still active, and is in the process of establishing legal argument, and amicus

briefs on issues relating to tort reform.

Because the request from the trial lawyers and labor came as a peremptory writ, the Supreme Court has original jurisdiction on the case. When this occurs, a shorter timeframe is involved for making decisions, says Maglione.

"This is another reason why doctors need to become more knowledgeable on the judicial candidates and their activities," he says. Future OSMA wins at the Statehouse are likely to be challenged in court, continues Maglione, so it's important for physicians to make a clear distinction between those candidates who exercise judicial restraint over those who practice judicial activism.

OHIO Medicine will keep you posted on new developments as they occur. ■



Candidate interviews... Secretary of State Bob Taft, candidate for governor, visited the OSMA's OMPAC board meeting in December to discuss his views on physician issues. Also pictured are, (from left) Dan Handel, MD, chair and Tim Maglione, director of the Department of Legislation.

OSMA Web site debuts in January

By the end of January you'll be able to access the latest OSMA information on our Web site at www.osma.org.

The Web site will be interactive, not only allowing members to keep in close touch with their association, but also providing them links to other useful sites, such as the AMA, the State Medical Board of Ohio, the Bureau of Workers' Compensation, the Ohio Department of Health

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PIE rehab...

continued from page 1

guaranty fund will cover claims remaining after the company's assets are liquidated. The cap on that fund is \$300,000 per claim. Most importantly, the Ohio Guaranty Fund is only liable for claims filed within one year of liquidation. If the insurance department decides to liquidate the company, all PIE policies are cancelled 30 days after the liquidation is filed. That means that physicians will be required to replace PIE policies with other liability insurance if they have not already done so prior to the liquidation order.

If you are a current or former insured of PIE, here's what the OSMA recommends that you do:

- Talk to your insurance agent about switching carriers or buying tail (prior acts) coverage. Many agents are recommending that current PIE insureds switch immediately and that former insureds, particularly physician retirees, purchase replacement tail coverage for the policy they received from PIE at their retirement. The quicker you switch to new coverage, the less likely you are to have uncovered claims. New prior acts coverage only applies to unknown claims. If you have received a 180 day notice letter or any other formal claim notice from a lawyer, a new prior acts policy will exclude it. OSMA has been informed that most current carriers are offering prior claim coverage with a transfer of current insurance to their companies. Several carriers are offering new replacement prior acts coverage also. Talk to your agent.

- Talk to representatives of your hospital to make certain that your new coverage meets the hospital's current minimum liability coverage standards. Some hospitals have already decided that PIE coverage is inadequate due to the possibility of the company's liquidation.

Although reports say the law firm that had a working relationship with PIE, Jacobson, Maynard and Tushman, is disbanding, some attorneys from that firm say they will continue to represent physicians who have PIE coverage.

The OSMA will provide information as this situation unfolds. ■

Indepth Report

Ohio expands child health coverage

Both a state and federal program will expand Medicaid benefits to more Ohio children than ever before.

More children of the working poor will be covered under Medicaid as the state rolls out its Medicaid expansion program Jan. 1. About 100,000 additional children under the age of 19 and in families with incomes up to 150% of the poverty level will be eligible for the new benefits immediately. By the end of this biennium (June 1999), the state expects its expansion project to cover about 133,000 children in all.

Still, almost 300,000 Ohio children are currently uninsured. To keep legislators focused on that problem, the OSMA, along with more than 30 other organizations, has helped form the Ohio Child Health Coalition to educate legislators on the federal money made available for children's health care through the budget bill last summer.

CHIP funds established

That act established the Children's Health Insurance Program (CHIP) which allows states additional money to expand Medicaid (or establish a separate program) to cover children up to

200% of poverty.

The catch is this: to receive the approximately \$115 million available to Ohio over the next two years, the state must come up with about \$48 million in matching funds. However, with legislators currently wrestling with the school funding issue, competition for the money will be tough.

"We are realists and recognize that school funding is a very important issue for the legislature," said Antoinette Eaton, MD, at a recent press conference. "But it is very important to point out that there is a very strong link between health and education. And while we recognize the importance and priority for the funding of education, we need to say that a child has to have adequate health care."

The state Department of Human Services continues to work on a framework that will cover the children if and when the federal funds become available. Meanwhile, the state expansion program will continue to operate.

Covering SSI ineligible

The department is also working to keep on its Medicaid rolls those children who have been dropped from the

Supplemental Security Income (SSI) program. New rules, which took effect July 1, call for children in this program to have a "medically determinable physical or mental impairment which results in marked and severe functional limitations."

The revised standards, however, have found thousands of Ohio children ineligible for the program which has caused concern in the child health community. Families have 60 days to appeal an ineligibility decision, but child advocates say many families don't know that an appeal is possible. Recently, the Ohio Legal Assistance Foundation (OLAF) implemented a statewide program that provides volunteer attorneys to help families through the appeals process. A toll-free hot line, 1-(888) 601-KIDS has been developed to provide information to families whose children have been denied benefits.

OSMA President Su-Pa Kang, MD, also wrote a letter to the state urging the department to do everything possible to see that the children dropped from the SSI program retain their Medicaid benefits. ■

Pages

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Is it unethical for a pediatrician to have sex with the patient's parent? The State Medical Board of Ohio makes a decision in the case of Toledo-area pediatrician Gary Gladieux, MD.



6

A new hospital moratorium will be one proposal the OHA: The Association of Hospitals and Health Systems places before legislators this year.

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Local health departments can be a physician's best resource on public health matters. Ohio Dept. of Health Medical Director Virginia Haller, MD, tells how to work effectively with your local and state health departments.



Bills, Laws & Rules



Board tackles thorny ethical issue

Technically, no rules or guidelines exist that say a doctor should not have sexual relations with a patient's parent, but the board decided medical ethics had been violated.

The case of Toledo-area pediatrician Gary Gladieux, MD, launched the State Medical Board of Ohio on a new examination of medical ethics and whether or not a line should be drawn if a physician has sexual relationships with the parent of a minor.

Dr. Gladieux acknowledged to the board that he had had mutual, consensual, sexual relationships with the mothers of at least seven of his young

patients. However, he said, no rules existed on the subject and physicians, pediatricians and ethicists who provided testimony to the board on the case (including the chair of the Ethics Committee of the American Academy of Pediatrics) had failed to produce any guidelines that prohibit such actions. Pediatricians consider the child, not the parent, to be the patient, he said, so, since he had not violated any known standards, he asked the board to be fair regarding its decision to discipline him, and to allow him to continue to practice.

However, an assistant attorney general, representing the state, pointed out to board members that the Ohio Su-

preme Court determined in 1990 that the medical board had the authority to interpret the principles of medical ethics and the standards of care, and that is what the board was asked to do in this case. Dr. Gladieux's actions had the potential of impacting patient care, even if not directly, and the board should discipline Dr. Gladieux accordingly.

Although there was much discussion on whether or not to proceed against Dr. Gladieux, the board finally determined that medical ethics in this case had been violated, and imposed on Dr. Gladieux a license suspension of not less than two years. ■

Court says no to late-term abortion ban

The federal appeals court in Cincinnati upheld a prior ruling that a state law banning so-called "partial birth" abortions is unconstitutional.

Although legislators passed a law that prohibited the controversial procedure several years ago, the law has been on hold since a federal district court declared it unconstitutional and prevented it from being enforced.

Arguments against the law were initially heard in U.S. District Court in Dayton. That court ruled that the law imposed on a woman's right to choose whether to have an abortion. The case then went to the 6th U.S. Circuit Court of Appeals which heard arguments in May. The court's decision, rendered last year, said the Ohio law went too far in its language banning dilation and evacuation (D&X) abortions. The court's decision, rendered last year, said that the ban on the D&X procedure placed a substantial obstacle in the path of women seeking abortions. The court also said that the language of the act was vague because it failed to adequately notify physicians of the conduct that is prohibited. The court accepted the argument that the description of the D&X procedure could include the more wide spread dilation and evacuation procedure. Regarding "medical necessity" and "medical emergency" determinations, the court said physicians could be civilly and criminally liable for adhering to their best medical judgment if, after the fact, another doctor said that the physician's judgment was not reasonable.

The appeals court decision may be appealed to the U.S. Supreme Court. ■

Statewide trauma data to be collected

A statewide trauma registry that tracks the care of critically injured patients will be implemented early this year. Data will be collected from all Ohio hospitals and will be sent to the Ohio Department of Public Safety for compilation. The information received into the registry will be confidential, however any reports issued by the department, based on the data, will be available as public information.

The concept for a trauma registry began in 1993, when the Emergency Medical Services Board created a trauma subcommittee specifically to establish a registry. Disagreements over how the registry is to be funded and data collected has delayed the project since that date. In the meantime, several larger Ohio counties, including Cuyahoga, Montgomery and Franklin, have created their own registries.

Although few dispute the need for a

statewide trauma registry, at issue is how this sensitive data would be released. The trauma subcommittee sought an opinion from the attorney general's office several years ago as to whether or not the data could be kept confidential. The attorney general's opinion was ambiguous, stating that the data could be considered protected but then it might not be.

A registry advisory committee of surgeons, emergency physicians, nurses, hospital administrators, EMS technicians and others will be responsible for generating reports and determining what reports to release.

As of press time, Ohio legislators are still awaiting the introduction of a proposed bill that would mandate a statewide trauma system. *OHIO Medicine* will keep you posted on that bill and on any new developments with the trauma registry. ■

Hot legislative topics for 1998

Ohio State Medical Association Legislative Director Tim Maglione predicts the following topics are likely to become hot legislative issues in 1998.

The OSMA Committee on State Legislation will meet later this month to set the association's legislative priorities for the year. No doubt these topics will be among the priorities selected.

- HMO accountability
- Ambulatory facility regulation
- Physician-business issues
- Allied professionals
- Patient access

Watch for stories on these issues in upcoming issues of *OHIO Medicine*. ■

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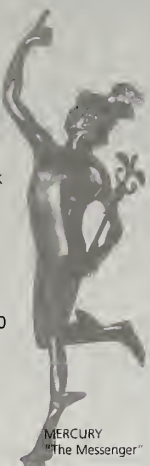
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OHA will seek moratorium on new hospitals

In addition to a 24-month "time-out," the OHA will also seek to define a hospital in state law.

OHA: The Association for Hospitals and Health Systems is likely to seek a moratorium this legislative session that would prohibit the building of new health-care facilities for a 24-month period (the moratorium would exclude ambulatory surgical facilities.)

Calling it a "time-out" the OHA Board of Trustees say the ban would allow health-care providers, including physicians, to study the now deregulated marketplace and better plan how such health-care resources could be utilized.

OSMA Councilors discussed the proposed moratorium at their November meeting and decided not to support the proposal. Their decision was based, in part, upon responses from OSMA's survey group of 400 members. A task force, assembled to consider the OHA proposal, studied the survey responses and subsequently recommended that market forces should continue to determine where and when hospitals should be built and that no one should be prohibited from entering the free marketplace.

OHA will continue with its plans for a moratorium, however, and, according to the November 1997 issue of the OHA's publication *OHA Advocate*, the association will also seek to define a hospital in state law as having at least 20 inpatient beds, staffed by a registered nurse 24-hours every day, and with a transfer policy in place with at least one other hospital. ■

Law now allows practice mix

The marketplace just became more interesting. The passage last year of Senate Bill 31 relaxes Ohio's ban on the corporate practice of medicine. That means physicians are now able to partner with optometrists, nurses, chiropractors, pharmacists, physical therapists and other health-care providers in combined practice arrangements.

The new law preserves the clinical autonomy of physicians who enter these arrangements and does not expand the scope of service of any of the providers mentioned in the bill. Nor does the bill address the employment of physicians by hospitals.

The OSMA had taken a neutral position on the bill. The Council decided to withdraw its traditional support of the ban on the corporate practice of medicine because recent changes in the health-care marketplace had made the ban obsolete.

If you have questions about the new law, contact Krista Bistline, OSMA Department of Legislation, 1-(800) 766-6762, Ext. 223. ■

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An outstanding opportunity exists for a board eligible/board certified Pediatric/Family Practice MD to join a newly created multi-specialty group in Marion, Ohio. This progressive community provides quality, yet affordable housing, excellent schools and an environment conducive to strong family growth. The close proximity to Columbus provides the opportunity to access larger city amenities, while living and working in a more suburban setting.

For more information, please contact: Marion Independent Physician Association, Inc., P.O. Box 0981, Marion, Ohio 43301-0981; phone (614) 387-7200.

OSMA/AMA advocate for doctors over Aetna contracts

The OSMA joins the AMA in its concern over Aetna/US Healthcare provider contracts.

In October, the AMA sent a letter, in conjunction with the Florida Medical Association, to Aetna/US Healthcare, stating concerns about physician contracts, including a provision that gives the carrier the right to unilaterally change patient care procedures and policies.

"The OSMA has known about the problems members have had with Aetna contracts for some time," says Carol Mullinax, director of OSMA's Division of Public Affairs.

Nancy Gillette, JD, OSMA legal counsel, adds that the OSMA has known since last summer that the AMA had planned to take this approach with the insurer.

Ohio physicians' chief complaint, says Gillette, is that Aetna shows no willingness to negotiate its contracts. "The doctor has to sign the contract or not sign it. It's an all-or-nothing approach," she says.

Bill Fry, director of OSMA's Ombudsman Services, says that most of the complaints he receives from members about Aetna relate to the carrier's capitation provision.

Capitation is not always a realistic payment mechanism for some physi-

cians. For example, a physician who sees a low volume of Aetna patients might lose money under a capitated rate if those patients need higher than normal physician services. Physicians always need to carefully evaluate capitation reimbursement proposals to see if they make economic sense for the physician's practice, says Gillette.

OSMA offers a contract review service through its Division of Legal Affairs, and members who use the service receive notice of the problems present in Aetna contracts, says Gillette.

"Many of the complaints that the AMA and Florida mentioned in its letter to Aetna are complaints that we have heard in Ohio as well," she says.

The OSMA continues to monitor member complaints about Aetna/US Healthcare and will continue to work with the AMA to alert attorneys there of the type of problems occurring in Ohio. *Ohio Medicine* will keep you posted on new developments as they occur.

Take Action

If you would like to have a copy of the OSMA's review of Aetna/US Healthcare's contract, contact the OSMA Division of Legal Affairs, 1-(800) 766-6762, Ext. 129, e-mail: legal@osma.org. ■

Guide details voting record

Want to know how U.S. Sen. Mike DeWine or U.S. Rep. John Kasich voted on key pieces of legislation last year? Then call for a free copy of the *U.S. Government: Owner's Manual*, published by Project Vote Smart, a national, nonpartisan research and information organization.

Inside the manual, you'll find assessments of Ohio's Congressional representatives, provided by competing special interest groups, where their campaign money came from and exactly how each member voted on important bills in 1997.

The manual provides information on how to contact these legislators as well. The books are funded by grants from the Carnegie and Ford foundations. For a free copy, call the Vote Smart toll-free hot line 1-(800) 622 SMART. ■

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County medical society news

Physicians told to act against profit-driven health care

Trumbull County

■ About 60 physicians in Trumbull and Mahoning counties attended a presentation, "Profits from Pain: The Corporate Destruction of Health Care in the USA," presented by the Trumbull County Medical Society.

The presentation was delivered by David U. Himmelstein, MD, of the Ad Hoc Committee to Defend Health Care, a Massachusetts-based, independent group of physicians and nurses which organized last year. The committee is touring the country in an effort to gather support for a moratorium of for-profit takeovers.

Ronald N. Khoury, MD, of Trumbull County, was responsible for bringing the program to the area. He, along with others, are contacting local medical staffs, asking them to take action to preserve the patient/physician relationship and to prohibit both the financial incentives which reward "under" care and the control of patient care by corporations and employers.

"It is the job of physicians to inform the general public and make them understand the seriousness of this issue," he says.

The Dec. 3, 1997 issue of *JAMA* includes an article and five pages of names of physicians and nurses endorsing the call for action.

Mahoning County

■ The Mahoning County Medical Society and the Northeastern Ohio Universities College of Medicine will sponsor a managed-care seminar, "Strategic Planning and Marketing for Change," Jan. 22 at Antone's Banquet Centre, Youngstown. The program will focus on marketing strategies. Physicians can earn 4 hours of AMA Category 1 CME. For more information contact Eleanor Pershing, Mahoning County Medical Society, (330) 788-4700.

Cuyahoga County

■ A new category of membership has been established by the Board of Directors of the Academy of Medicine of Cleveland. This membership is designed specifically for the nonphysician administrators, managers of medical practices and key personnel working for active members of the academy. The purpose of the membership is to provide a forum where personnel in physicians' offices can share information and ideas facing physicians in office practice. The dues for the associate membership are \$75.

Hamilton County

■ The Academy of Medicine of Cincinnati is studying the feasibility of

distributing "report cards" to members that would allow them to indicate their satisfaction or dissatisfaction with health-care plans. Physicians may be able to "grade" plans on what is denied or allowed in the way of care, and the amount of time physicians and their staff spend waiting on the phone when they call an HMO. To make this a tool, rather than a weapon, medical directors from each of the area's major managed-care plans will be included in the committee that creates the report card. The report card idea has met with approval of the Health Care Plan Value Project's sponsor, the Employers Health Care Alliance of Greater Cincinnati. ■

JAY JOHANNIGMAN, MD, Cincinnati, has been appointed director of trauma and surgical critical care at Jewish Hospital Kenwood. He will be evaluating resources and making recommendations for development of trauma services at Kenwood.

FLOYD LOOP, MD, Cleveland, was awarded the 1997 American Red Cross Humanitarian Award in November. This award is presented to an individual(s) who embodies the spirit of the American Red Cross through their contributions to the welfare and quality of life of the Greater Cleveland community. Dr. Loop was nominated for his personal and professional commitment to public health issues and human betterment at both a local and national level. Bernadine Healy, MD, was also presented with the humanitarian award.

MICHAEL NUSSBAUM, MD, Cincinnati, a general surgeon, has been elected chair of Jewish Hospital's Drug Policy Development Committee.

DANIEL RENNER, MD, Mayfield Heights., Chief of Thoracic Surgery at Meridia Hillcrest Hospital, worked as a general surgeon on a medical mission trip in Kazakhstan from June 20, 1997 through July 6, 1997. He and his wife were part of the Operation Blessing mission team.

ROSLYN SELIGMAN, MD, Cincinnati, has been awarded status as a diplomate of the American Board of Forensic Examiners and the American Board of Forensic Medicine. She is a psychiatrist.

JAMES F. GUILTY, JR., MD, Cleveland, was awarded the distinguished honor of 1997's Pediatrician of the Year. Dr. Guilty, who has devoted his life to the care of children and the betterment of their lives, was awarded this honor in August and received a plaque signed by Governor Voinovich.

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Specialty News

OOS named "model" society

The Ohio Ophthalmological Society (OOS) was recently named one of 18 "Model State Societies" for 1997. The OOS received the recognition in October at a special ceremony at the American Academy of Ophthalmology's Annual Meeting in San Francisco. The society was recognized for excellence in member and organizational development, legislative and regulatory advocacy, third-party relations, public information/public service and professional education projects during 1996. ■

Group Practice

Wooster/Cleveland clinics merge

Wooster Clinic has merged with the Cleveland Clinic Foundation, following 18 months of negotiations.

"Our goal is to keep health care as local as possible while increasing and improving our available services," says James Murphy, MD, Wooster Clinic's board president.

Wooster Clinic will retain its name and board of directors, and its management operations will remain in Wooster. Through its affiliation with the Cleveland Clinic, however, Wooster Clinic patients will now have access to specialists who do not currently practice at their local facility, and will be referred to the Cleveland Clinic for treatment if they require care beyond the services provided at Wooster Community Hospital. Eventually, new staff will be added to the Wooster Clinic staff.

Both clinics are physician-owned and multispecialty. ■

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The Ohio State Medical Association, in conjunction with the Adams Physician Advisory, has planned the following seminars for January and February.

Exploring the New Evaluation and Management Guidelines

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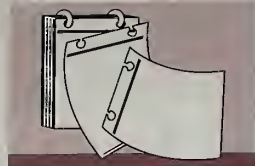
- Correctly documenting the elements of evaluation and management codes;
- New HCFA requirements for examinations;
- Single organ system examination requirements;
- Multisystem examination requirements.

Jan. 28 – SeaGate Convention Center, Toledo

Jan. 30 – Sheraton Suites, Cuyahoga Falls

Feb. 11 – Holiday Inn Eastgate, Cincinnati

Feb. 13 – Concourse Hotel, Columbus



Calendar

- The rules for record retention.
- Legal issues concerning record release.

Jan. 27 – SeaGate Convention Center, Toledo

Jan. 29 – Sheraton Suites, Cuyahoga Falls

Feb. 10 – Holiday Inn Eastgate, Cincinnati

Feb. 12 – Concourse Hotel, Columbus

The Ohio State Medical Association, in conjunction with Conomikes Inc., will sponsor the following practice-management seminars.

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If you'd like to register, contact the OSMA's Department of Meeting Management at 1-(800) 766-6762, Ext. 136.

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Identifying public health as a concern for their constituencies, OSMA and ODH plan to encourage the development of working relationships between county medical societies and local health departments. Letters from Su-Pa Kang, MD, OSMA president and Bill Ryan, director of health, will ask their local colleagues to become familiar with each others' organization and membership. This might occur, for example, through co-hosting of a regular membership meeting or mutual planning of a continuing medical education event. Physician knowledge of local health department staff can lay the groundwork for uncertain or crisis situations which demand quick response from the community. Likewise, local public health officials rely on your expertise in assessing and tracking various health conditions.

In future editions of *OHIO Medicine*, members of the Public Health Committee will contribute articles on a range of subjects. Your questions and suggestions for topics are welcome. Contact the OSMA at 1-(800) 766-6762, Ext. 222 – Virginia Haller, MD, Medical Director, Ohio Department of Health

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Streamlined Annual Meeting what delegates prefer

When delegates and alternates meet in Cleveland May 15-17 for the 1998 Ohio State Medical Association's Annual Meeting they'll find a new format. A survey conducted at the last year's meeting concluded that delegates wanted a shorter, more streamlined meeting. Councilors approved the new schedule last September.

The Opening Session, usually held Friday evening, will start at 10 a.m. Saturday and include the installation of Lance A. Talmage, MD, as the new OSMA president. Resolution committee hearings will be held from 1-4 p.m. followed by district caucuses if needed. The remainder of Saturday will be spent preparing resolution reports and conducting candidate interviews. The evening will conclude with a presidential reception.

District caucuses will meet Sunday morning prior to the 10 a.m. Final Session of the House of Delegates.

This abbreviated schedule allows those interested in attending the Organized Medical Staff Section Meeting on Friday, May 14, from 1-4 p.m. an opportunity to do so.

Resolution deadline is 5 p.m. March 16. Resolutions must be mailed to the Executive Director, Brent Mulgrew, Ohio State Medical Association, 1500 Lake Shore Dr., Columbus, Ohio 43204.

OHIO Medicine as well as the OSMA Web site (www.osma.org) will keep you posted on further developments. For more information, contact Susie Paulus, Annual Meeting Coordinator, at 1-(800) 766-6762, Ext. 115.

See the chart at right for a complete schedule:

Friday

8 a.m.-noon:	OSMA Council
1-4 p.m.:	Organized Medical Staff Section Meeting
4-5 p.m.:	New delegate briefing AMA delegation meeting Emergency resolution meeting OMERF board meeting
5-7 p.m.:	District caucuses

Saturday

7 a.m.:	Possible caucus
10 a.m.- noon:	Opening Session, House of Delegates, Presidential Installation

1-4 p.m.:	Resolution committee hearings
3-5 p.m.:	OMPAC board meeting
4 p.m.:	District caucuses if needed
4 p.m.:	Resolution report preparation
4:30-6 p.m.:	Candidate interviews
6:30 p.m.:	Presidential reception

Sunday

7-10 a.m.:	District caucuses
10 a.m.-4 p.m.:	Final Session, House of Delegates
4-6:30 p.m.:	OSMA Council

Alliance Report Move beyond the words

It seems to me that the strength of New Year's Resolutions comes not in their making but in their testing. After all, everyone makes resolutions with the best of intentions, it's in the day-to-day, week-to-week,

month-to-month testing of these commitments that they reveal their value to us. It's in the practicing of these commitments that we change and grow.



Denise Kneisley

It's the same way with the OSMA Alliance. "This year," you may have resolved, "I'll join the OSMA Alliance." I won't quibble with the resolution. It's a good one. But not until you move beyond the words will you begin to understand the value of membership in the OSMA Alliance.

Let me cite, for you, our mission statement: "The mission of the Ohio State Medical Association Alliance is to support, promote and enhance the goals of the Ohio State Medical Association and the American Medical Association Alliance: to organize, educate and stimulate members in a manner that will ensure improvement of the quality of life through health education and charitable services throughout the state."

Those aren't meaningless words, so many cast-aside resolutions. The OSMA Alliance works hard to make that mission statement a reality. You've read in these pages about our work with SAVE, the acronym for Stop America's Violence Everywhere. We were the ones who distributed book-marks and placemats to awaken children and their parents to the dangers

continued on page 14

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Move beyond...

continued from page 12

gers that increasing violence brings to our society. You saw on the front page of this publication last month that the AMA's Extinguisher character was brought into Ohio schools to preach the no-smoking message to children. We were the ones who brought him here.

My guess is, few physician spouses could find fault with our mission. That's why you make the resolution: "This year, I will join the OSMA Alliance." I challenge you, however, to go beyond the words. I challenge you to join our group.

Obviously, I'm not speaking to all OSMA members. I am, however, addressing that group of physicians who are spouses of physicians. It doesn't matter which spouse, wife or husband. The OSMA Alliance wants and needs men as well as women among our ranks. Of course, we'd appreciate any time you could give us, but we realize that's not always possible. You're a practicing physician, too. However, becoming a member, even in dues only makes a statement of support in our mission. And it's that support that helps us change and grow.

So go ahead, make the resolution: "This year, I will join the OSMA Alliance." But this year, move beyond the words. ■

New councilor appointed

J. Steven Polsley, MD, Urbana, has resigned his position as Second District Councilor due to personal and family commitments. The remainder of his term will be filled by Allen H. Klein, MD, until the Annual Meeting in May when the House of Delegates will select a new councilor.

President's Perspectives

History is trying to repeat itself

In 1987 the OSMA successfully lobbied for tort reform in the Ohio General Assembly only to see the law later dismantled by the Ohio Supreme Court.

In 1996 the OSMA again successfully lobbied for tort reform in the Ohio General Assembly. Just recently a coalition of trial lawyers and the Ohio AFL-CIO filed suit to have the new law declared unconstitutional by the Ohio Supreme Court.



Su-Pa Kang, MD

The fact that the law would be challenged is not a surprise. The Ohio Alliance for Civil Justice, the coalition that the OSMA participated in to achieve tort reform,

had anticipated and planned for court challenges. One way we did this was to structure the new law to make the provisions less likely to be overturned by the court. Also, in cooperation with the Alliance, we formed a Court Watch program to monitor any suit that is filed against the tort-reform law. The Alliance then works to establish legal arguments and file amicus briefs in support of the law. And, in a more long term approach, we continue to work with a group called Ohio Citizens Against Lawsuit Abuse to raise public awareness about the impact of our judicial system.

However, this new court challenge has unexpected momentum and strength behind it. This is due, in large part, to the recent victory trial lawyers and labor experienced in repealing the workers' compensation reform law. In 1997 the state legislature successfully passed a comprehensive law to address fraud and abuse in the workers' compensation system. Trial lawyers and many unions were unhappy with the new law and sought to repeal the measure.

The OSMA, even though we were struggling with our own concerns about the managed care portions of the new law, urged members to vote "yes" on Issue 2 so that the new law would stay on the books.

However, in November, Ohioans voted to repeal the new law. The experts may still be debating the results, but I have my own opinions. Certainly, many voters had to find the way the referendum was structured misleading. Asking voters to vote "yes" to stop a repeal effort creates confusion. In addition, I think that some physicians — those who are currently experiencing problems with the Ohio Bureau of Workers' Compensation transition to managed care — may have found it difficult to vote "yes," even though the referendum had nothing to do with managed care.

Whatever the reasons for the repeal, with this victory behind them, the same coalition of personal injury lawyers and labor unions have turned their sights to the tort reform law. And, because the challenge is in the form of a writ of prohibition and mandamus, the Ohio Supreme Court has original jurisdiction on the issue and will likely hear the case on a much faster time frame.

You can count on the fact that the OSMA and the Alliance for Civil Justice will vigorously defend any and all attacks on the recently-enacted tort-reform law. But to be successful in this effort, we need your help. We must all work together in becoming more educated about judges and their philosophies regarding judicial activism versus judicial restraint, in other words, distinguish those judges who like to make law versus those who interpret the law.

In addition, we must educate our patients and the public about the importance of the new law and the protection it offers to them and their families.

If we do that, perhaps common sense will prevail in our civil justice system. Then, as we strive to control costs while protecting the quality of health care, one thing we won't have to worry about is the cost of defensive medicine. And we will have won in our fight to keep history from repeating itself. ■

Obituaries

JOSEPH D. ALTER MD, Dayton, Hahnemann Medical College of Philadelphia, Philadelphia, PA, 1950; age 74; died Nov. 16, 1997.

KENNETH D. ARN MD, Dayton, University of Michigan Medical School, Ann Arbor, MI, 1946; age 76; died Nov. 28, 1997.

JAMES D. BARI MD, Toledo, University of Michigan Medical School, Ann Arbor, MI, 1969; age 54; died Nov. 25, 1997.

JOSEPH E. BAUSMAN MD, Piqua, University of Cincinnati College of Medicine, Cincinnati, OH, 1933; age 90; died Oct. 27, 1997.

LLOYD D. BONAR MD, North Ridgeville, University of Cincinnati College of Medicine, Cincinnati, OH, 1952; age 71; died Oct. 27, 1997.

ARTHUR DOYLE MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, OH, 1952; age 81; died Nov. 19, 1997.

EDMUND V. DRUKTEINIS MD, Florida, Vytuta Didzia University Medical Fakelata, Kaunas, Lithuania, 1942; age 81; died Oct. 25, 1997.

FREEMAN FLETCHER MD, Cleveland, Dartmouth Medical School, Hanover, NH, 1975; age 63; died Nov. 26, 1997.

OLIGHERD C. GARLO MD, Holland, Vytuta Didzia University Medical Fakelata, Kaunas, Lithuania, 1943; age 78; died Nov. 14, 1997.

CECIL W. HALES MD, Wilmington, OH, Ohio State University College of Medicine, Columbus, OH, 1946; age 76; died Nov. 4, 1997.

FRANCIS P. KINTZ MD, Florida, Ohio State University College of Medicine, Columbus, OH 1931; age 95; died Nov. 13, 1997.

ROSANNA KOCH MD, Columbus, Medizinische Fakultät der Univ Heidelberg Baden-Württemberg, Germany, 1951; age 78; died Nov. 19, 1997.

WILLIAM H. MILLER, JR, MD, Grafton, University of Pittsburgh School of Medicine, Pittsburgh, PA, 1943; age 79; Nov. 5, 1997.

BERNARD H. ROBERTS MD, Middletown, New York University School of Medicine, New York, NY, 1950; age 80; died Nov. 17, 1997.

EDMUND ROTHFELD MD, Cincinnati, Faculté de Médecine de l'Université de Lausanne, Switzerland, 1939; age 82; died Nov. 17, 1997.

KLAUS L. STEMMER MD, Cincinnati, Medizinische Fakultät der George August Univ, Niedersachsen, Göttingen, Germany, 1951; age 78; died Nov. 23, 1997.

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Practice Tips

Legislative home pages give insight into process

Editor's Note: As part of its Computer Chat column, OHIO Medicine will periodically report on computer software available for medical professionals. The OSMA, however, does not endorse any software product. The reports published here are for informational/educational purposes only.

Now you can take a tour of the Statehouse without leaving home. The General Assembly recently launched Internet home pages that provide users information about the House and Senate's members, their committee assignments and histories of the chambers.

The pages can be accessed via the Gongwer News Service home page at <http://www.gongwer-oh.com>. They can also be reached by selecting the "Ohio General Assembly" link on the Gongwer page.

The Senate site can be accessed directly at www.ohiosenate.org; the House site at www.house.state.oh.us; and the Statehouse tour at www.statehouse.state.oh.us. A general legislative home page can be accessed at www.legislature.state.oh.us.

While the House and Senate pages contain mostly organizational information, the plan is to add information on pending bills, Legislative Service Commission analyses and other legislative documents.

Other new services available via computer and another helpful Web site are listed as follows:

■ Routing medical bills

Advanced Micro Technologies, Inc., Columbus, has contracted with a workers' compensation system VAN (Sac3) out of Huntsville, Alabama, to route medical bills to managed-care organizations for health-care providers.

Here's how the program works.



Computer Chat

For the MCOs:

All workers' compensation managed-care organizations receive free software to install on a PC-compatible computer with modem. This software enables users to dial into a secure, point-to-point network to retrieve medical bills which have been sent to them by health-care providers participating in the Ohio workers' compensation system. Providers must have the provider version of the software in their office.

There is no charge to the MCOs for the software, and no charge for the MCOs to print the bills at their office. MCOs are encouraged to participate so that providers can reduce the expense of sending paper bills.

For the providers:

Software is available free to any interested health-care provider. A provider pays only \$0.35 per bill for first report of injury sent through this network to the VAN (Sac3).

In return for their money, providers receive:

- a confirmation with date that the MCO has received their document
- a secure proprietary network for sending and receiving medical information
- free training and technical support
- no monthly fees or Internet access

- required
- same day receipt of their bill by an MCO
- faster turnaround of payments

For more information contact, Kevin Penhorwood, president of Advanced Micro Technologies, Inc. at (614) 478-5161.

■ Industrial Commission

The Industrial Commission of Ohio, the judicial arm of Ohio's Workers' Compensation System, can now be accessed on the World Wide Web.

The site went online in November. If you call up the site at www.ic.state.oh.us, you'll find a page of information on members of the commission, a page on the agency's role in Ohio's workers' compensation system and a page listing telephone and fax numbers of IC offices across the state. ■

OSMA Web site...

continued from page 1

and others. Physician input has helped shape the kind of information and links that will go onto the site.

Members will be able to leave e-mail messages for staff which will be answered within 24-hours.

Electronic communications, such as the Web site and e-mail, is the OSMA's way of adapting to members' ever-changing needs, allowing the association to broaden its communications efforts.

The Web site will continue to be "a work in progress" — growing as members' interests and needs grow.

Let us know what you think of the Web site or what you would like to see added, call the *OHIO Medicine* reader response line at 1-(800) 766-6762, Ext. 228 and leave a message. ■

Medicare roundup

• **PAR status date extended...**Because the 1998 Medicare physician fee schedule conversion factor was delayed "for a number of reasons" (it didn't mail until Dec. 15), physicians will be given until Feb. 1 to decide whether or not they wish to serve as a participating provider in the Medicare program. Typically, physicians must declare their PAR status by Dec. 31. If you are currently a participant, and choose not to continue as a Medicare provider, you should write to each carrier to which you submit claims, advising them of your termination effective Jan. 1. This written notice must be received prior to Feb. 2. If you change your participation status after Jan. 1, you should begin submitting claims in accordance with your decision as soon as you make it.

• **Notify Medicare of practice changes...**If you have recently changed your practice locations, left or joined a group practice, added a new physician to your practice or made any other changes, you need to notify Medicare now. Here's how to shorten the notification time: Fax Medicare in advance if you know that a change in your practice (for whatever reason) is coming up. Medicare will send back a form for you to complete, Form 855, HCFA's written notification of change. Medicare officials say they will process your request and send you the form the same day. "That is likely to cut out at least two weeks from the 8-10 weeks it usually takes to make the change," says Bill Fry, director of OSMA's Ombudsman Services. Don't forget, if you are joining a new group, you will need to tell Medicare both what group you are leaving and what group you are joining. The fax number to use is (614) 677-1191. Helpful tips on the 855 form can be found at www.nationwide-health.com.

• **Medicare Web site...**The latest information on Medicare changes, fee schedule conversion factors, lab fees, etc. can be accessed at your convenience on the World Wide Web. The Web site address is www.hcfa.gov.

• **Medical director retires...**Alice Faryna, MD, medical director of Ohio's Medicare office will retire early this year. Her replacement is Ruth Ann Holzhauser, MD. ■

MCOs have input on Medicaid rates

When managed-care organizations (MCOs) claimed that Medicaid reimbursement rates were so low they risked financial ruin, legislators formed a Medicaid Managed Care Reimbursement Subcommittee to consider the matter.

The result is that MCOs will now have 240 days to develop Medicaid rates that they believe are fairer to those HMOs and other entities that contract with the state to provide health care for Medicaid enrollees. The time frame is meant to allow MCOs enough time to consider how the rates impact the marketplace and to make business decisions accordingly. ■

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A Publication of the Ohio State Medical Association

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Contract issues

Hold-harmless clauses: a red flag for doctors

This column will discuss important points and language that physicians should be aware of before signing plan contracts. The OSMA also offers members a contract review service. For more information about this service, contact the OSMA Division of Legal Affairs at 1-(800) 766-6762.

The malpractice case has been tried (or settled), and suddenly you, not your carrier, must pay the attorney fees, court costs and the entire amount of the settlement.

That's what can happen if the plan contract you signed includes a hold-harmless clause. These provisions are used by a plan to shift liability to you in cases of alleged malpractice, making you responsible for payment of malpractice claims brought by the plan's enrollees.

Generally, this type of contractually assumed liability is NOT covered by standard malpractice insurance policies.

Red flags

Some hold-harmless language is explicit in contracts, sometimes the hold-harmless provision is implied. Before you sign a contract, watch for these red flags:

- Clauses that use the language "hold-harmless," "indemnification," or that make the physician "solely" or "exclusively" responsible for medical care or treatment decisions.

- Any attempt to protect the plan from sharing the risk

of incorrect decisions, improper coverage and UR decisions.

- Language that states that regardless of the plan's refusal to authorize care, the physician accepts sole responsibility for medical care.

Protect yourself

There are two actions you should take before you sign any contract that contains explicit or implied hold-harmless provisions:

- Ask your malpractice carrier to review all indemnification or hold-harmless clauses. Your carrier will be able to tell you whether, by signing the contract, you are assuming liability that is not covered under your malpractice policy.

- If possible, negotiate deletion of such provisions in your contract so as to avoid complications in the event of litigation. You want to be sure your malpractice insurance will cover enrollee's claims.

Take Action

The information for this column comes from the Division of Legal Affairs, and from "Book 2: Contracting Issues," which is part of the *Navigating Change* handbook series published by the OSMA. For information about ordering a copy of Book 2, contact Robin Parker, Division of Public Affairs, at 1-(800) 766-6762, Ext. 216. ■

Ask the Legal Department

Court order not necessary for DUI's blood sample

Q. Should I comply with a request from a police officer to draw blood from a suspect who is unconscious and unable to give consent for the procedure?

A. The law governing the withdrawal of blood from unconscious patients can be summarized as follows:

1. Medical personnel may comply with requests from police officers for blood samples from unconscious individuals suspected of driving under the influence of alcohol, drugs or other substances (DUI) provided that the withdrawing of blood will not endanger the patient's health. The law provides medical personnel with immunity from criminal liability and from civil liability for assault and battery in such situations.

2. If a medical facility chooses to take the position that its personnel will not be allowed to withdraw blood from unconscious patients when requested by law-enforcement officers, the medical personnel should not interfere with the efforts of law-enforcement officers to obtain a blood sample through the use of a physician or nurse brought to the hospital by police officers for the specific purpose of withdrawing blood from the patient. Interference with such evidence gathering could be viewed as the crimes of obstruction of justice or obstruction of official business.

3. If a medical practitioner is presented with a situation where a law-enforcement officer seeks a blood sample from a person who is not accused of DUI, the medical practitioner should refuse to draw such a blood sample unless there is a court order such as a search warrant specifically ordering such a test.

4. For dead patients, all testing should be conducted by the county coroner.

Ohio Revised Code 4511.191 provides that all persons who operate motor vehicles on Ohio's public high-

ways give their implied consent to submit to tests to determine the content of alcohol or drugs in their blood. This applies, as well, to persons incapable of consenting to such tests.

Civil liability still present

It's not battery or an illegal act for a physician to withdraw blood from a drunk driving suspect when requested to do so by a police officer. Ohio law (RC 4511.19(D)(4)) provides hospital personnel with immunity from criminal liability and from civil liability for assault and battery under these circumstances. However, hospital personnel can still be sued for medical malpractice under circumstances where they negligently withdraw blood from a patient.

Medical personnel should refuse to draw blood samples in situations where law-enforcement officers request blood samples from unconscious patients who are not accused of DUI, unless ordered to do so by the court.

Court order for non-DUIs

Courts have established that a warrant is not required to obtain a blood

test from the DUI suspect because it is a search incident to an arrest and because the testing needs to be done quickly, because a person's blood alcohol content tends to rapidly diminish after a person stops drinking.

However, sometimes police officers will want to obtain blood samples from suspects to test for DNA. Because of recent advances in DNA technology, DNA testing is likely to become a more common criminal investigative tool, which will necessarily lead to an increase in the volume of requests for blood testing. In dealing with these requests for blood, medical personnel should only draw blood from an unconscious patient at the request of law-enforcement officers if a search warrant or other type of court order has been obtained. Because DNA evidence does not diminish over time like evidence of alcohol and drugs, there is no exigency that excuses the requirement of obtaining a search warrant. Thus, a search warrant is required to obtain blood from a suspect who is accused of a crime other than DUI. ■

Information for this column was supplied by Richard J. Ryman and Ron Mangis, attorneys with Reminger & Reminger Co., LPA, Cleveland.

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February 1998

Ohio Medicine

Publication of the Ohio State Medical Association

Association seeks MCO accountability

The OSMA strongly supports legislation introduced in the Ohio House of Representatives that make HMOs and other health plans accountable for denial of care decisions.

Co-sponsors Rep. Randall Gardner (R-Bowling Green) and Rep. Pat Tiberi (R-Columbus) worked closely with the OSMA in developing House Bill 677. It is based, in part, on a similar law that was recently enacted in Texas.

The Gardner/Tiberi bill joins several other efforts under way in Ohio that focus attention on the issue of managed-care accountability. (See story at right.)

As it is currently drafted, the proposed legislation clearly establishes the accountability of managed-care organizations that engage in negligent medical decision-making resulting in patient injury—for example, negative outcomes as a result of denials in coverage of prescribed care or delays in receiving that care.

Due to the fact that 1998 is an election year and the Legislature is approaching deadline on solving the school funding crisis, it may be difficult to fully resolve this issue in 1998. However, the OSMA believes strongly that public awareness needs to be raised over the issue of MCO accountability.

For additional information, please contact: Tim Maglione, director of the OSMA Legislation Department at 1-(800) 766-6762, Ext. 220, or Nick Lashutka, associate director, at Ext. 226. ■

Managed-care back at Statehouse

More reform bills follow the success of Physician-Health Plan Partnership Act, the measure supported by both the OSMA and Kaiser Permanente.

Legislation, introduced in both the House and Senate late last year, proposes new areas of managed-care reform, not covered in the Physician-Health Plan Partnership Act (PHPPA). The PHPPA, sponsored by the OSMA and Kaiser Permanente, was passed by the Ohio Legislature and will become fully effective in the fall of 1998. The new bills are as follows:

- House Bill 641, sponsored by Rep. Betty Sutton (R-Barberton), is a legislative attempt to make Health Maintenance Organizations and other managed-care entities liable for the medical decisions they render. The bill creates a legal cause of action against any insurer or health insuring corporation that causes injury or damages as the result of interfering with the provision of certain health-care services. The OSMA will be pursuing a separate legislative proposal dealing with HMO accountability, a measure that would hold HMOs accountable for negligent utilization review decisions. (See story at left.)

- Senate Bill 206, sponsored by Sen. Grace Drake (R-Solon), establishes a grievance structure for enrollees not happy with their plan. Specifically, the bill:

- 1.) Requires health-care plans to establish complaint procedures consistent with listed requirements;
- 2.) Provides rule-making authority to the director of the Ohio Department of Health for implementing these complaints procedures;
- 3.) Establishes a managed-care ombudsman office at the ODH to investigate complaints against health-care plans; and

continued on page 3



Walter E. Beasley, MD, Marion, right, OSMA Third District Councillor, becomes acquainted with Sen. Larry A. Mumper (R-Marion). Sen. Mumper replaces Sen. Karen Gillmar. As term limits begin to take effect, it becomes increasingly important for more physicians to become involved with their legislators. *Ohio Medicine* will look at the effect of term limits in the March issue.

HCFA announces E&M guidelines enforcement delay

Responding to a request by the AMA, HCFA recently announced that it will delay enforcement of the new Evaluation and Management Documentation Guidelines until June 30, 1998. This essentially extends the "grace period" for requiring the use of these guidelines as the only standard for E&M documentation for another six months. Originally, the grace period ended on Dec. 31, 1997.

HCFA is advising physicians that documentation of their E&M services must, at a minimum, meet documentation guidelines that were developed jointly by HCFA and the AMA and released in 1994. Ohio's local carrier, Nationwide-Medicare, will be conducting pre-payment audits during the grace period so physicians may still be randomly audited for documentation accuracy. ■



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4.) Requires plans to notify enrollees prior to terminating or limiting health-care services that are covered.

The OSMA is monitoring both bills but has not yet taken a position on either measure.

In the meantime, the OSMA testified recently on a managed-care bill that has been under discussion in the House since early last year. House Bill 99, sponsored by Rep. Donald Mottley (R-West Carrollton), creates a legislative task force to study access issues, including point-of-service plans. OSMA Legislation Director Tim Maglione supported the bill, telling legislators that patients' increasing frustration over denied access to their physicians makes the time right for a policy discussion on the subject. ■

Take Action

If you have questions or would like more information about any of the bills mentioned in this story, contact the OSMA Department of Legislation, 1-(800) 766-6762, e-mail: legis@osma.org.

Bills, Laws & Rules



Medical board report

Board aware of confusion over subpoenas

When a physician receives a letter from the State Medical Board of Ohio, subpoenaing patient charts, he or she figures that's not a good sign. Is the medical board investigating his or her practice? Why?

In truth, the board may or may not be investigating your practice, just as the subpoena states. The board has the right to subpoena charts from one physician in its investigation of another, but you have no way of knowing whether it's your practice or a colleague's practice that the board is reviewing.

At its November meeting, medical board members noted that physicians are frustrated by this lack of information, but finding a remedy isn't easy.

State Medical Board investigations are confidential. Obviously, the board can't release the name of the person under investigation, but neither can it tell you that someone else is the reason your patient records have been subpoenaed. As board member Thomas Gretter, MD, explains, telling the other physician that he or she is not the subject of the investigation may help him or her determine who the subject is.

The board is aware of the aggravation this creates for physicians and is working toward a solution. In the meantime, you need to cooperate with

Board elects new officers

The State Medical Board of Ohio has named the following new officers:

President: David S. Buchan, DPM, Columbus

Vice-President: Anita M. Steinbergh, DO, Westerville

Secretary: Anand G. Garg, MD, Boardman

Supervising Member: Raymond J. Albert, Amanda

Nora M. Noble, Newark, is the board's Immediate Past President.

the board, and send your records when you receive a subpoena.

Of note...

• **Physician profiles...** The board may consider placing licensee names and information on the home page of its Web site, as well as joining a national profiling system known as Docfinder. According to the board's Executive Director Ray Bumgarner, the Docfinder program recently stopped the passage of legislation in two states that would

have required physician profiling. Since those states were affiliated with the Docfinder program, legislators reasoned the information was already available to the public and voted the bills down.

Along those lines, the Federation of State Medical Boards is considering the possibility of entering data on all licensed physicians from every state into their computer banks. This will allow state boards to have immediate access to disciplinary action taken against a physician. If the project is approved, it may be operational by 1999.

• **Nurses and amniotomies...** At the request of St. Ann's Hospital in Columbus, the board's Scope of Practice Committee reviewed whether or not performing amniotomies fall within the scope of practice of registered nurses. A literature search by the committee indicated a significant amount of complications with these procedures, and little benefit to patients. Following extensive discussion, the committee recommended that the board inform St. Ann's that amniotomies were beyond the scope of registered nurses. The board adopted the committee's recommendation. ■

Pages

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Can insurers force their policyholders to arbitrate their disputes? The Ohio Supreme Court will decide if policyholders can settle their disagreements over the arbitration table or in court.



8

The quest for quality cardiac care has prompted Anthem to form a statewide coronary care network and the OSMA/OHA to collaborate on collecting cardiac care data.

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Northeast Ohio is the site of a new OSMA program that is likely to strengthen ties between the association and doctors in that region.



22

Do you need a surety bond? Despite what some companies are telling you about the federal budget bill, you may not need to buy a bond at all.

Can't serve jury duty? These excuses are still valid

Now that physicians will no longer be exempt from calls to jury duty, you may want to take note of the excuses for not serving that are still allowed by Ohio courts.

Senate Bill 69, which passed the Legislature this year, eliminates exemptions from service as a juror and increases the compensation paid to jurors and grand jurors.

The bill still exempts cloistered members of religious organizations from jury service, but now other clerics, lawyers, senior citizens and doctors will have to respond to the summons to appear – unless they meet one of the following criteria:

- The demands of your business require a temporary excuse.
- You are away from the county on necessary business and won't return

- in time to serve.
- The interests of the public or your own interests will be materially injured if you take time away to serve.
- You're physically unable to serve.
- Your spouse or near relative has died recently or is dangerously ill.
- You've already served as a juror for a trial in a county court that year.

Each excuse will be considered on a case-by-case basis.

If you're not eager to serve as a juror but don't qualify for an excused absence, you can look on the bright side. Your payment as a juror could now be as high as \$40 a day. ■



Due to the passage of Senate Bill 69, physicians will no longer be exempt from jury duty. The bill exempts only cloistered members of religious organizations from jury service.

Bill passed Electronic signatures are now valid

Ohio physicians may now use electronic signatures on medical records, due to the recent passage of House Bill 243 which establishes standards for using electronic signatures on health-care records.

Before the measure passed, the Senate Health Committee stripped the bill of a controversial provision that would have imposed a fee for obtaining copies of medical records. Health Committee Chair Sen. Grace Drake (R-Solon), says that issue will be addressed later, in separate legislation.

In addition to allowing the use of electronic signatures, HB 243 also designates October as "Ohio Breast Cancer Awareness Month" and an "Ohio Mammography Day," also in October. The bill was sponsored by Rep. Dale Van Vyven (R-Sharonville) and supported by the OSMHA.

Along the same vein, Senate Bill 183, which has passed the Senate, names October as "Ohio Hepatitis C Awareness Month." The bill's sponsor, Sen. Drake, calls Hepatitis C a growing public health threat that currently affects about 4 million Americans. The bill is under consideration in the House Health Committee.

According to an article in *Business First*, the increase in Hepatitis C cases is due in large part to the illicit drug use practiced during the late '60s and into the '70s. The baby boomer population who took drugs through hypodermic needles are said to be the largest group of Hepatitis C patients. Yet only 10% of those infected with Hepatitis C during the early stages know of its existence. The proposed legislation is expected to bring much-needed awareness of the disease to Ohioans. An estimated 201,110 Ohioans could be infected by the disease.

The bill is under consideration in the House Health Committee. ■

Update

Anthem responds to lawsuits

As reported in previous issues of *Ohio Medicine*, two groups of Cincinnati physicians filed lawsuits last year against Anthem Blue Cross and Blue Shield, alleging that the carrier dropped them from its provider networks, even though the doctors accepted the insurer's reimbursement rates. The suits seemed to be an attempt to reintroduce the issue of an any-willing-provider concept through a common law approach.

Statement issued

Ohio Medicine reported on the plaintiff side of the lawsuit in November and at the same time asked Anthem for an interview to clarify its position on the suits. Anthem requested that a list of questions be forwarded to them for response by its legal department. The response, in the form of a statement, was received in time for our

February issue.

In its response, Anthem noted that many of its provider contracts contain provisions allowing termination both for cause and without cause as an "essential component of effective network management."

"From time to time," Anthem's statement continues, "Anthem may reconfigure its provider networks to provide improved access and convenience to members and contracting providers." In doing so, Anthem says it exercises its without-cause termination provision.

Although it terminated "certain orthopedists and neurologists in the Cincinnati area over the past two years," Anthem says the providers were merely terminated from participation in certain managed-care networks.

When the physicians filed their suits, Anthem responded by filing mo-

vements to dismiss, arguing that the contracts permitted termination without cause by either party and that Ohio is not an any-willing-provider state.

One suit dismissed

On Dec. 1, 1997, the state court granted Anthem's motion to dismiss the orthopedists' suit and has ordered the suit dismissed. The court found that the contract between Anthem and the physicians governed terminations, and the physicians were bound by those determinations.

The plaintiff's argument that public policy precluded termination is a legislative function, said the court, and not within the scope of the judiciary.

Physicians from the orthopedists group reapplied for participation in certain Anthem networks and have been re-admitted.

The federal case remains pending. ■

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Can insurers force arbitration?

The Ohio Supreme Court has been asked to decide whether or not health insurers can require their policyholders to arbitrate disputes over covered medical procedures.

In the case before the court, a state employee, covered by CIGNA Healthcare of Ohio, requested coverage for a new surgical treatment for liver cancer. The insurer considered the treatment experimental and refused to cover it under her policy. The policyholder and her husband sued to force CIGNA to pay for the treatment, but the insurer appealed on the grounds that the health insurance contract calls for disputes to be settled by arbitration. (During the course of the suit, the state employee died.)

The appellate court ruled that the policyholder's claim must be arbitrated, but that her husband's claims could be settled in court. CIGNA appealed that decision to the Supreme Court. In presenting arguments before the court in December, a CIGNA attorney asserted that because the policyholder agreed to the arbitration clause, her husband's claim should also be arbitrated.

The plaintiff's attorney argued that access to the courts and a jury trial is a fundamental right that must be knowingly waived and the individual's right to a trial can't be waived by an employer or other party.



"The case probably will not affect provider contracts," says OSMA legal counsel Nancy Gillette, JD. *Ohio Medicine* will provide updates on this case as they develop. ■

Take Action:

Many insurers do include arbitration provisions in their contracts and physicians should be aware of what arbitration entails, including who pays for the process. For more information, see "Contract Issues" on page 21.

Ohioans want tobacco control

Ohioans want to end youth smoking, even if that means establishing a notional tobacco control policy.

The American Cancer Society released, recently, the results of a telephone poll of more than 800 Ohioans. Of those surveyed, 74% believe that Congress needs to develop a policy that helps control youth smoking. And time is of the essence—81% of survey respondents feel it's important for federal lawmakers to address the issue in the next six months.

Meanwhile, Ohio already has tobacco control bills pending at the Statehouse.

Senate Bill 152, sponsored by Sen. Rhine McLin (D-Dayton) prohibits minors from purchasing or possessing any tobacco product.

Officials with Tobacco Free Ohio, however, want a more comprehensive approach to tobacco control, including penalties for retailers who sell tobacco products to minors.

Sen. Nancy Chiles Dix (R-Hebron) will introduce a bill that fines retail store owners if the clerks they employ sell tobacco to minors. Currently, only clerks are fined if they permit youths to buy cigarettes and other tobacco products.

The OSMA is monitoring SB 152, and at press time, Sen. Dix had not yet introduced her bill so the OSMA has not had an opportunity to review it. ■



In a recent telephone survey of 800, 74% of Ohioans believe that Congress needs to develop a policy that helps control youth smoking.

Gladieux resumes practice

Although his license was suspended by the State Medical Board, a court ordered a temporary stay.

The Toledo pediatrician whose license was suspended by the State Medical Board of Ohio because he had sex with the mothers of his patients (see January issue of *Ohio Medicine*), has been granted a temporary stay in Franklin County Common Pleas Court.

The stay allows Gary Gladieux, MD, to continue to practice medicine, despite the state board's actions, if he meets the following three requirements:

- 1.) He shall have no romantic or sexual contact with any family member of his patients nor any unescorted contact with any female relatives of his patients.
- 2.) He must notify the families of his current patients that he has been suspended for not less than two years for violating the AMA's Principles of Medical Ethics, although he may tell them that he has won a stay of the board's order.
- 3.) He must notify new patients of the suspension and stay on their first visit to his office.

Dr. Gladieux has moved his practice from Toledo to Swanton.

In his appeal to the court, Gladieux's attorney states that the board exceeded its authority by imposing a sanction against a doctor for private conduct, in violation of his rights to liberty and privacy.

Briefs by the attorney general's office, representing the board, as well as by Gladieux's attorney are due to the court by Feb. 20. A hearing is likely to be held soon after that deadline. ■

Supporters act to stop tort-reform lawsuit

Now that Ohio's tort-reform law is in court, supporters of the statute have stepped forward to assure its viability.

Trial lawyers and the Ohio AFL-CIO filed a lawsuit against the act in late November, claiming it is unconstitutional.

State Attorney General Betty Montgomery has asked the Ohio Supreme Court to dismiss the lawsuit, saying that neither trial lawyers nor labor can demonstrate that any of its members or any Ohio citizen has been harmed by the law. A suit, she adds, must be based on demonstrable injury or harm to person or property, supported by evidence. The suit, she said, only predicts the possible effects of the law.

In addition, several county judges have also asked the Supreme Court to dismiss the suit. In their statement, the judges say the Supreme Court has no jurisdiction in the matter, since such challenges are generally reviewed by lower courts first. In fact, those on both sides of the tort-reform issue expect the law to be tested in Ohio's trial and appeals courts over the next few years.

That's why the Ohio Alliance for Civil Justice, a coalition (including the OSMA) that supported the tort-reform measure, established a CourtWatch program that monitors and files responses to suits that challenge the tort-reform law. The Alliance filed a friend-of-the-court brief shortly after the trial lawyers and labor announced their lawsuit.

According to Tim Maglione, OSMA Director of Legislation and co-chair of the Alliance, there are more than 60 cases pending in lower courts that challenge the tort-reform law. At least one of those suits, filed last February by the National Lawyer's Guild of Cleveland, has been dismissed. ■

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Dateline Ohio

Anthem claims coronary network improves cardiac care for all

Quality cardiac care has become a focus since the disbanding of the state's certificate of need program.

Anthem Blue Cross and Blue Shield says its statewide Coronary Services Network, implemented in 1994, has had a positive impact on mortality rates and improved the quality of care, not only for their enrollees but for all Ohioans with cardiovascular disease.

Jeannie Kassan, RN, vice president for Quality Improvement, Anthem Midwest Region, calls it the ripple effect. As hospitals improve their cardiac units to meet Anthem's network criteria, all of Ohio's cardiac patients receive better quality care, she says.

Anthem's Chief Medical Director, Joseph Berman, MD, agrees: "You hear all the time about how managed care drives down the quality of health care. This is an example of how managed care has raised the level of quality care."

According to Anthem, since forming its network, the mortality rates for patients using network hospitals are well-below national averages; the rate

of heart attack within 24 hours of surgery is 64% lower; and the average length of hospital stay for bypass surgery with cardiac catheterization has declined 27%.

To qualify as a network hospital, says Kassan, the facility must perform at least 250 cardiac operations a year. The hospital is then evaluated on a number of factors, including the number of complications and the mortality

"You hear all the time about how managed care drives down the quality of health care. This is an example of how managed care has raised the level of quality care."



Joseph Berman, MD

rates. Anthem also reviews cardiac surgeons' and cardiologists' offices to assure that standards are met.

Data from claims and patient outcomes helped to shape the evaluation criteria and continue to be collected from the network hospitals so that improvements can be made as necessary.

Despite pressures to release this data, Dr. Berman says Anthem will keep the information confidential and will not release it to the public or to outside providers.

OHA/OSMA effort similar

Mary Yost, spokesperson for the OHA: Association for Hospitals and Health Systems, says that while she has no comment on the Anthem program, it is in line with the type of work that will be done by the Cardiac Quality Care Foundation, a collaborative arrangement between the OSMA, the OHA and its member hospitals to collect data on cardiac care services.

"There is a growing movement to provide consumers and health-care providers with more quality outcomes data," she says.

It's also the law. When Senate Bill 50 was enacted, disbanding the state's certificate of need program, the measure also required that quality standards be put in place for certain health-care services, including cardiac care. In addition, the law requires the Ohio Department of Health to collect outcomes data on these services.

Yost says the foundation is still in its beginning stages, but once it's operational, the goal is to offer its data services to the ODH, and to supply good cardiac care data in Ohio to both health-care providers and consumers.

"It's the trend," she says about collecting outcomes data as a means to ensure quality care. "It's definitely the way the marketplace is headed." ■

Opinion Data sharing helps define best practices

By Stanley Borg, DO

The rise in improving quality is occurring because data collection and the sharing of information are powerful tools that are molding and improving our overall health-care system. Medical data already shows that those hospitals and surgeons who perform more cardiac procedures have better outcomes.

In 1992, the frequency, cost and public interest in cardiac procedures relating to coronary artery disease caused Anthem Blue Cross and Blue Shield to focus efforts on hospitals performing cardiac surgery to determine which of those facilities provided high-quality care at a competitive price. Initial information received from these hospitals demonstrated marked differences in performance. As a result, Anthem established a process to continually assess and recognize those hospitals demonstrating high-quality, invasive cardiac services for its membership.

In fact, this process of measuring data has created a spill-over effect and is improving cardiac care for all Ohioans today.

While only those hospitals which demonstrate high-quality outcomes are offered to Anthem members, the forum of data collection and information-sharing is open to any willing Ohio hospital performing invasive cardiac services which met minimum volume requirements and have acceptable, overall hospital quality score. Quarterly meetings—held for hospital administrators, nurses and physicians from Coronary Service Network medical centers statewide—allow for the sharing of new technology, clinical data and the review of pre-and post-operative care. Surgeons hear from other surgeons, and nurses hear from other nurses in a cooperative way that al-

State responds to OSMA's SSI letter

OSMA President Su-Pa Kang, MD, received a response from the Ohio Department of Human Services regarding his request that the state maintain Medicaid eligibility for those individuals who lost the Supplemental Security Income (SSI) as a result of redetermination of disability status.

State Human Services Director Arnold Tompkins writes that the department is in the process of contacting the 10,000 or so individuals in Ohio who might lose their SSI benefits. Tompkins says, if a person loses the SSI benefit, he or she should still be eligible for Medicaid.

These individuals will also receive information about assistance through Legal Aid, if SSI eligibility is denied. The individual (or parents) should contact the following number within 60 days. The number is: 1-(888) 601-5437.

Physicians are urged to cooperate with parents in collecting medical records. ■

lows for an Ohio best practice to be formed. Facilities also evaluate their own clinical pathway and processes against those of their peers.

Most importantly, physician and hospital care givers are part of the process that determines how data is defined and outcomes are measured. Infection after surgery, MI-after surgery, and death rates are among the data sets. Severity adjustment factors also are discussed and agreed upon. The process is a collaborative effort between the providers and Anthem.

Anthem then analyzes the data and distributes confidential scorecards to all hospitals. Facilities meeting quality benchmarks are considered for contract negotiations. Network hospitals scoring very high in the quality rating also are offered a monetary bonus in recognition of their superior performance within the screening criteria established. Some hospitals which did not initially qualify for the Coronary Services Network made improvements to quality after the annual data cycle was repeated. There are other sentinel effects, too. Many Ohio hospitals show a general trend toward service improvements as well.

Data, now available, demonstrate that cardiac care in Ohio has improved. Through the use of this information, physicians are able to define best practices. Patients soon will be able to assess which hospitals and physicians use them. ■

Stonley Borg, DO, is the medical director for Anthem Blue Cross and Blue Shield in Columbus. If you would like to discuss the Coronary Service Network with Dr. Borg, you may contact him at (614) 438-3862.

Young physician nominees sought

Do you know any young physicians who are outstanding in their profession and their community? Send your candidate or candidates name (s) and resume (s) to: *Ohio Medicine*, Outstanding Young Physician Award, 1500 Lake Shore Drive, Columbus, OH 43204. ■

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AMA Interim meeting focused on Sunbeam

Two key issues came under focus at the AMA Interim Meeting last December in Dallas, reports Walter A. Reiling, MD, chair of the Ohio Delegation to the AMA. One of those issues dealt with concern over the AMA's endorsement of Sunbeam products.

"There were mixed feelings on this subject," says Dr. Reiling. One argument, both inside and outside the Ohio delegation, urged the AMA to further investigate how the endorsement was put into place. "This group wanted to assure that nothing was hidden," says Dr. Reiling. "They wanted to know this wouldn't happen again." Others believed that the internal investigation already conducted by the AMA was thorough, and wanted the matter brought to closure.

The House voted, finally, to ban AMA endorsements of products it doesn't produce, and appointed an independent ad hoc committee, composed of House of Delegates members, to in-

vestigate how the Sunbeam arrangement slipped through the process, and was endorsed without board of trustee approval.

E&M guideline enforcement opposed

The second topic to generate discussion, both in the House and in the delegation, dealt with HCFA's intention to enforce the new Evaluation and Management Documentation Guidelines. Members of the House urged the AMA to vigorously oppose the enforcement, primarily for two reasons, says Dr. Reiling.

"We object to the 'most-favored-nation' provision," he notes. This clause tells doctors that they are unable to receive from Medicare any reimbursement over the lowest rate paid by a carrier with whom they are under contract. Not only is this reimbursement issue deemed unfair, says Dr. Reiling, but the Office of the Inspector General has stated it intends to find doctors who ac-

cept higher payments from Medicare guilty of fraudulent practices. "There is the potential for huge fines," says Dr. Reiling.

At the AMA's request, HCFA announced it would delay the enforcement of the new guidelines until June 30, 1998 to allow physicians to become more familiar with documentation requirements, but HCFA is advising physicians that documentation of the E&M services must, at a minimum, meet documentation guidelines that were developed jointly by HCFA and the AMA, and released in 1994.

Other highlights

Dr. Reiling mentioned the following issues as among other topics discussed in some depth at the meeting:

- **Tobacco settlement.** The AMA House voted to oppose any settlement with the tobacco industry that would protect the industry from civil liability.
- **Public health issues.** "There were

a number of public health and safety issues addressed, including the safety of the birth-control product, Norplant," says Dr. Reiling.

- **Deaf interpreters.** Members of the Ohio delegation were interested in this subject, primarily because advocates for the deaf in Ohio have become more outspoken about the availability of signers for deaf patients in doctors' offices. While Dr. Reiling says the American with Disabilities Act has merit in ensuring that hearing-impaired patients can communicate with their doctors, fees for signers can be more expensive than the cost of the office visit. The House referred the resolution to the AMA board.

- **Increased medical student representation.** Medical students proposed that they be allowed one delegate and alternate delegate per 1,000 members. The matter was debated at some length, then referred to the AMA board. ■

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Date: March 4
Time: 8-9 am
Hours: 1.0
Title: Annual OSHA Update
Where: Robinson Memorial Hospital, Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: March 6-7
Title: Palliative Medicine '98
Where: Hyatt Regency Pier 66, Ft. Lauderdale, FL
Sponsor: Cleveland Clinic Foundation
Contact: Alyce Bell, (216) 444-5696

Date: March 11
Time: 8-9 am
Hours: 1.0
Title: Liver Function Testing
Where: Robinson Memorial Hospital, Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: March 14
Time: 8:30 am-3:30 pm
Hours: 6.5
Cost: \$80
Title: Cancer Management for Primary Care Clinicians
Where: Cleveland South Hillan Inn
Sponsor: University Hospitals/Cleveland
Contact: CME Registrar, (216) 844-5050

Date: March 25
Time: 8-9 am
Hours: 1.0
Title: Diabetic Foot Infections
Where: Robinson Memorial Hospital, Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: March 25-28
Title: Gynecology Update
Where: Honolulu, Hawaii
Sponsor: Good Samaritan Hospital, Cincinnati
Contact: Marian Barton, (513) 569-6631

April

Date: April 1
Time: 8-9 am
Hours: 1.0
Title: Endometrial Cancer
Where: Robinson Memorial Hospital, Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: April 8
Time: 8-9 am
Hours: 1.0
Title: Extra Nodal Lymphoma
Where: Robinson Memorial Hospital, Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: April 15
Time: 8-9 am
Hours: 1.0
Title: Melanoma
Where: Robinson Memorial Hospital, Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: April 17-19
Hours: 17.5
Cost: \$200-\$375
Title: Esophageal Diseases
Where: Renaissance Cleveland Hotel, Cleveland
Sponsor: Cleveland Clinic Foundation
Contact: Alyce Bell, (216) 444-5696

For more listings visit the OSMa Web site at www.osmo.org

ODH takes over AIDS testing analysis



The Ohio Department of Health (ODH) assumed responsibility last month for the analysis of HIV-testing formerly performed by labs in Cleveland, Columbus and Dayton, and that has some local health officials wondering how the state can handle such an increase in tests and still maintain quality control.

The decision was an economic one, says ODH Director William Ryan in an article in the *Cleveland Plain Dealer*. Labs that, last year, collected \$280,000 in federal money will now watch those funds go to the ODH lab. The money is needed, says Ryan, to help subsidize a variety of free services the state lab is expected to provide communities.

The tab for the state-run lab is expected to come to \$7 million next year, but because the legislature eliminated the lab's subsidy from the general fund in the last budget bill, the state is left to find its own operational monies.

Still, local health directors are concerned with the type of service their customers can expect with one laboratory responsible for such an increase in screenings. Said one local lab official, "Somebody better be organized." ■

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Forum

Physicians, MCOs, Worker's Comp: Who grades whom?

By Patrick McCormick, MD

Most Ohio physicians involved in the treatment of workers' compensation patients know that the system is undergoing tremendous restructuring. A fundamental piece in this restructuring has been the introduction of Managed-Care Organizations (MCOs) to orchestrate the delivery of care to injured workers in Ohio. The Bureau of Workers' Compensation (BWC), which previously handled these tasks, is now assuming a role of an oversight body which determines the allowableness of claims, collects premiums, and makes payments for services rendered to claimants. The bureau also is charged with adjudicating disputes between claimants and their MCOs. This program, entitled the Health Partnership Program (HPP), has been the end result of long and difficult negotiations between all of the various stakeholders involved in the management of Workers' Compensation claims



Patrick McCormick, MD

Assuring quality is key

The physicians and other providers involved in these negotiations took great pains to ensure that the MCOs would be given incentives to recognize and support the highest quality of care to the injured workers. It was determined that MCOs would not be able to generate windfall profits by simply slashing the provider fee schedule, enlisting whatever providers they could get to work under such a fee schedule and pocketing the difference. Instead, it was felt that the MCOs would not be able to profit unless they achieved demonstrable measures of quality in terms of patient care and outcome. This in turn would motivate MCOs to identify the best providers in the community

and develop a fee schedule, enticing these providers to be a member of their panel in order to achieve quality ratings. MCOs would then profit by drawing from bonus pools of money set aside to acknowledge such performance.

Cost vs. quality

Unfortunately, the process hinges on the issue of measuring quality care. The instrument for measuring an MCO's performance will be a grade card, and the parameters graded will directly influence the behavior of MCOs. After all, the MCO stands to profit if they can obtain "good grades" and will fail to profit if they obtain "poor grades." If an MCO is graded on cost savings, then it will be motivated to enlist those providers willing to work for their lowest acceptable fee schedule and to limit resources available to injured workers as much as possible. On the other hand, if the MCO were to be graded on quality outcome measures, such as accurate diagnosis, timely treatment, and rapid return to normal functional status, it would provide MCOs the incentive to develop a panel of the highest quality providers, functioning under treatment guidelines that ensure rapid diagnosis and timely treatment.

In reality, it is much easier to develop parameters that grade an MCO's economic performance than it is to develop parameters to grade patient and disease-specific outcomes. Broad measures of patient satisfaction will fail to capture this information because, frankly, a satisfied patient is not the same as a patient who has received the highest quality care available. The two may be one in the same, then again, a patient who is given total disability for what is otherwise a treatable condition may well be "quite satisfied."

Physicians, as well as other care providers, need to come forth and identify themselves as the best possible judges of an MCO's commitment to delivering quality care directed at the best possible outcome on a patient-specific and disease-specific basis. It is the

physician, as the provider within the system, who can best determine the commitment and cooperation of the MCO to develop provider panels and treatment programs that identify, pursue, and ensure the quality outcome for those with work-related injuries.

Provider communities, led by physicians, should have a voice in the grade card system used to assess MCO performance. At present, there is no opportunity for physicians to have input, nor is there any current commitment on the part of the bureau to allow for input.

I believe physicians should develop a grading system for the MCOs and invite other provider communities to participate in this grading process. In this way, the relative performance of each MCO can be analyzed from a provider perspective. MCOs both above and below the average performance could be identified, and this information used to improve or reward their performance as well as educate the employer and employee groups regarding the merits of various MCO options available to them.

Provider perspective important

In addition, collecting and collating these data would demonstrate to the bureau how important the provider perspective is to adequately assessing the performance of an MCO, especially in terms of quality of patient care. This should greatly increase the likelihood that the provider community will have a permanent place in the standard report card developed and issued for the various MCOs participating in the HPP.

At the direction of its Task Force on Bureau of Workers' Compensation, the Ohio State Medical Association has begun reviewing the feasibility of working collaboratively with other health provider organizations to develop an MCO-specific grading system by the provider community. ■

Patrick McCormick, MD, Toledo, is chair of the OSMA Workers' Compensation Task Force.

Letters

Chronic pain needs multidisciplinary approach

To the Editor:

To quote Ernest W. Johnson, MD, "I was both enthused and disappointed to read Letters to the Editor, Interdisciplinary approach needed for pain control." (Letters to the Editor, *Ohio Medicine*, December 1997) Enthused because Dr. Johnson pointed out that pain may be only the presenting complaint of a complex problem.

However, I was disappointed with his statement, "to close 'nonmalignant' chronic pain patients with narcotics is to miss the major problems as well as to inundate, nauseate, and constipate persons who deserve more appropriate and propitious treatment."

If the chronic pain syndrome is characterized by a severely dysfunctional life style centered around avoiding or reducing pain then multidisciplinary management is most certainly recommended. In a biopsychosocial framework, the physician-healer should recognize that significant issues are more about caring and healing than specific tools. Whether these tools be invasive technology, physical rehabilitation, cognitive behavioral approaches or narcotics, they bave value as long as they return the patient to productivity and a pain-free state. This would be true for chronic malignant or chronic nonmalignant intractable pain.

DOUGLAS M. GOLDSMITH, DO, FAOCA

Clinical Professor, Anesthesia and Pain Control, Ohio University, Youngstown

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County medical society news Cleveland physicians rate managed-care plans

Cuyahoga County

Members of The Academy of Medicine of Cleveland received a survey recently asking them to evaluate the managed-care plans in the Greater Cleveland area. Members were asked to rate the plans in several areas—communications, referral process, capitation, compensation and reimbursement—on a scale of 1 to 5, one being highly satisfied and five being highly dissatisfied. Results of the survey will be available to members, managed-care plans and the public.

■ The academy, in cooperation with the Columbus Medical Association, the Academy of Medicine of Cincinnati and the OSMA, is negotiating a plan to create a statewide credentialing service. The Ohio Physician Accreditation Service (OPAS) plans to increase the number of hospitals using the service for credentialing physicians and to seek accreditation by the National Committee for Quality Assurance (NCQA). If they get the NCQA accreditation, OPAS could then provide credentialing for managed-care organizations. The OPAS main headquarters will be in Columbus.

Stark County

Nancy Adams, the former executive director of the Stark County Medical Society, is the 1997 recipient of the medical society's Lifetime Achievement Award. The award is presented in recognition of outstanding service to the society and the medical profession. Adams had served as executive director for 18 years. She had been instrumental in developing numerous educational and legislative programs for the membership. Her contributions to the community, through her mini-internship program, has been recognized nationally.



Nancy Adams

Hamilton County

A \$3.5 million grant from the Choice-Care Foundation moved plans for the Health Education Center of Greater Cincinnati Inc., a little closer to fruition. The community resource center, focusing on health, wellness and disease prevention was initiated by the Academy of Medicine of Cincinnati in 1992. It is scheduled for completion in 2000. An executive director and governing board should be in place early this year.

■ Ohio Attorney General Betty Montgomery will address the issue of for-profit hospitals taking over not-for-profit hospitals at a joint meeting of the academy and the Cincinnati Bar As-



Betty Montgomery

sociation on March 5 at the academy's Daniel Drake Auditorium. Cost is \$30 for academy and bar members, and \$40 for nonmembers. Call Zand Walters at the Bar Association for reservations, (513) 651-5118, Ext. 217.

■ The Physician-Patient Advocacy Committee, recently formed by the academy, plans to address well-documented, quality of care issues and help mediate those matters. The committee will use the recently passed OSMA-sponsored Physician-Health Plan Partnership Act, as well as the American Medical Association's newly formed Division of Representation, in seeking solutions to these problems. Edouard Feghali, MD, is chair.

New members join OSMA

The following physicians have joined the OSMA as new members:

Bruce B. Banias, MD,
Beavercreek
Olubukola D. Bolaji, MD,
Sycamore
James Corwin, MD,
Cincinnati
Ramandeep Dhillon, DO,
Wooster
Kevin W. Kammler, DO,
Portsmouth
Marc S. Krakow, MD,
Kirtland
Benigo P. Lazaro, MD,
Warren
Antonio M. Licata, DO,

Centerville
Joseph R. McShannic,
MD, Akron
Alan T. Mong, MD,
Chillicothe
James L. Mosher, MD,
Loveland
Melinda S. New, MD,
Cincinnati
Thomas Bao Nguyen, MD,
Cincinnati
Terri L. Overbeck-Zisko,
MD, Cincinnati
David B. Parrett, MD,
Zanesville

RONALD C. AGRESTA, MD, who has an ophthalmology practice in Steubenville, was elected to the board of directors of the Federation of State Medical Boards of the United States for a term that expires in April 2000. Dr. Agresta has been a member of the Ohio State Medical Board since 1988, serving as vice president in 1992 and president in 1993.

ALVIN H. CRAWFORD, MD, Cincinnati, was visiting professor of the 5th GCC Orthopaedic Association Conference held in Jeddah, Saudi Arabia. He provided consultation to children with orthopaedic problems and lectured on children's fractures, clubfoot deformities and the use of video-assisted thoracoscopy in the management of spinal deformities in children.

ALBERT N. MAY, MD, Morion, was recently appointed by the American Hospital Association, to serve on the Accreditation Council for Continuing Medical Education for a three-year term beginning January 1998. He currently serves as chair of the OSMA's Committee on Accreditation of CME Sponsors, is associate professor of pediatrics for the OSU College of Medicine, participates on a committee member for the Association for Hospitals and Health Systems and is chief of pediatrics for the Smith Clinic in Morion.

MICHAEL MISHKIND, MD, Columbus, has been named 1997-98 president of the Columbus Medical Association. He is a clinical assistant professor of medicine at OSU Medical Center, senior attending physician and director of dialysis at Riverside Methodist Hospital, and chair of Riverside's Department of Medicine.

President's Perspectives

Broken resolutions? Here's one to keep

It's February, and if you find that the well-intentioned resolutions you made in January have already been forgotten, I have a suggestion. Let's make one resolution that will be easy to keep, and will do more for us than all those self-improvement commitments we made in January.

Let's make nowadays, 1998, the year we expand our role as patient advocate. Nowadays, patients are increasingly confused and bewildered by our complex health-care delivery system. Managed care, for good or



Su-Po Kong, MD

bad, has established an increasing number of hoops which our patients must jump through in order to receive reimbursement for their care.

That's where we come in, through our active involvement in the Ohio State Medical Association. Two bills that we supported last year, the Managed-Care Uniform Licensure Act (MCULA) and the Physician-Health Plan Partnership Act (PHPPA), have become law. Both will help our patients navigate through today's complex health system. How? By requiring plans to explain to their enrollees, in easy-to-understand terms, what's covered, what's not—and how to appeal a decision if necessary.

One of the new laws, the Physician-Health Plan Partnership Act, also mandates physician involvement in medical decision-making. Now, appeals of adverse determinations must be reviewed by a clinical peer. Physicians are also given greater authority to use nonformulary drugs

and must comprise the majority of each plan's formulary committee so that physician input is gathered upfront. Furthermore, plans must involve physicians in the development, implementation and evaluation of quality assurance programs.

Perhaps PHPPA's most important role, however, is to establish a defined process for the resolution of patient grievances—while protecting physicians who act as advocates for their patients during this process. Plans are prohibited, under PHPPA, from retaliating against either physicians or patients for these activities. Both of these new measures will ensure that physicians and patients have the tools necessary to function more effectively in the health-care marketplace.

As organized medicine, the OSMA will continue to examine ways to gain more legislative and regulatory relief for our patients. But we should not stop here.

We can, and should, reach out to our patients individually as well. Let's work with them to resolve coverage problems, helping them with their appeals when their payments have been denied or their medications changed. Yes, it may take some time, but I assure you it will be time well spent. Our patients' health and well-being can only improve as a result. Now isn't that a resolution worth keeping? ■

For a list of new members see story on page 14.

The OSMA, in conjunction with the Adams Physician Advisory, has planned the following seminars for February.

Exploring the New Evaluation and Management Guidelines

This full-day workshop covers the new HCFA documentation guidelines for evaluation and management procedures. A workbook is included. Participants will review:

- Correctly documenting the elements of evaluation and management codes;
- New HCFA requirements for examinations;
- Single organ system examination requirements;
- Multisystem examination requirements.

Feb. 11 – Holiday Inn Eastgate, Cincinnati

Feb. 13 – Concourse Hotel, Columbus

Principles of Documentation

This full-day program will explore the various principles of documentation and recordkeeping. In this workshop, participants will learn:

- How to correct patients' charts.
- How to design and use consent and signature forms.
- What should be in an operative report.
- The guidelines for radiology and pathology reports.
- Correct documentation of E/M codes.

Educational program focuses on International Medical Graduates

Immigration law, J-1 Visa policies and managed-care issues will highlight the International Medical Graduate Program March 27-28 sponsored by the OSMA and its IMG Task Force in cooperation with the OSMA's component county medical societies in northeast Ohio.

The two-day event will kick off with a reception from 7:30 p.m. to 9 p.m. Friday, March 27 at the Sheraton Suites Hotel, Cuyahoga Falls.

Following a continental breakfast Saturday, the morning session will include a presentation on immigration law and J-1 Visa policies plus an update from a State Medical Board representative during the luncheon. Su-Pa Kang, MD, president of the OSMA, will update physicians on what the OSMA is doing for them.

The afternoon program will include a panel discussion with members of the OSMA IMG Task Force, update on current legislation impacting Ohio physicians, and a managed-care segment.

For more information, contact Doug Evans, OSMA director of Membership Services at 1-(800) 766-6762, Ext. 105. ■



Calendar

- The rules for record retention.
- Legal issues concerning record release.

Feb. 10 – Holiday Inn Eastgate, Cincinnati

Feb. 12 – Concourse Hotel, Columbus

The Ohio State Medical Association, in conjunction with Cononikes Inc., will sponsor the following practice-management seminars.

Financial Management

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To register, contact the OSMA's Department of Meeting Management at 1-(800) 766-6762, Ext. 136. ■

OSMA tests "field rep" in northeast Ohio

Ben Reynolds has joined the OSMA staff in a new position as Field Representative, northeast Ohio. Although he will be based in Akron, Reynolds will be responsible for representing the OSMA to the physicians and component medical societies in 13 counties in northeast Ohio.



Ben Reynolds

"I'll be a presence in their community,"

Reynolds says, "members, as well as nonmembers, will be able to put a 'face' with the association."

The idea of a field representative is not new.

Other state medical associations have successfully implemented programs that use a geographically-based representative to strengthen communications with member and even nonmember physicians.

According to Doug Evans, director of OSMA's Division of Membership Services, the concept for an OSMA field representative grew out of focus group discussions held in 1996, prior to the Task Force 2000 meetings. Task Force 2000 members encouraged the OSMA to develop a field rep program.

"We initiated the effort in northeast Ohio for several reasons," says Evans. Historically, this section of the state is an area where the OSMA has experienced success in as well as the need for membership recruitment. The 13 counties also represent the area of the state that has the largest concentration of physicians. "We couldn't select a group of counties in any other part of the state and reach as many physicians as we can in this area of the northeast," he says.

This initial effort will be evaluated by the OSMA to determine if the program should be expanded to other regions of the state, and, if so, how this is to be done.

Meanwhile, Reynolds will be out in the field talking to physicians, physician leaders, councilors and county medical society representatives, to find out how the OSMA can better serve its members. "My goal is to have every member served as quickly as possible," he says. He'll talk with nonmembers as well to determine what needs still haven't been met. These contacts, too, will help strengthen the association.

Reynolds spent the first few weeks of December at the OSMA headquarters in Columbus learning about the OSMA, its structure, services and benefits of membership. A native of West Virginia, Reynolds most recently served as director of ArtSmart for the Nashville Institute for the Arts in Nashville, Tenn.

Reynolds can be reached at: (330) 535-1429 or e-mail him at: alefsung@aol.com.

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Obituaries

ROBERT L. BENNETT, MD, Akron, Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1964; age 60; died Dec. 1, 1997.

WILLIAM S. DEFFINGER, MD, Marengo, University of Cincinnati College of Medicine, Cincinnati, 1941; age 81; died Dec. 6, 1997.

CHARLES FROUG, MD, Florida, Eclectic Medical College, Cincinnati, 1935; age 85; died Dec. 9, 1997.

JEROME GERBER, MD, Toledo, Chicago Medical School, Chicago, 1947; age 75; died Dec. 7, 1997.

LEONARD GOTTESMAN, MD, FACS, Cincinnati, St. Louis University School of Medicine, St. Louis, 1940; age 83; died Dec. 15, 1997.

CLIFFORD G. GRULEE JR., MD, Cincinnati, Northwestern University Medical School, Chicago, 1938; age 85; died Jan. 2, 1998.

PAUL V. HAMILTON, MD, Cincinnati, Vanderbilt University School of Medicine, Nashville, TN, 1929; age 94; died Jan. 1, 1998.

DAVID EDWARD LEHTINEN, MD, Cleveland, University of Western Ontario Faculty of Med., London, Ontario, 1969; age 54; died Dec. 28, 1997.

MORRIS STANFORD OSHER, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1938; age 85; died Jan. 2, 1998.

WALTER W. RANDOLPH JR., MD, Delaware, Ohio State University College of Medicine, Columbus, OH, 1958; age 65; died Dec. 5, 1997.

CHARLES A.E. SEBASTIAN, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1938; age 85; died Dec. 8, 1997.

KENNETH W. TAYLOR, MD, Pickerington, Ohio State University College of Medicine, Columbus, OH, 1930; age 92; died Dec. 8, 1997.

JOHN W. WASHINGTON, MD, Dayton, Meharry Medical College, Nashville, TN, 1948; age 76; died Jan. 1, 1998.

IAN M. WILLIAMSON, MD, Toledo, Faculty of Medicine, Univ. Of Glasgow, Glasgow, Scotland, 1964; age 57; died Dec. 7, 1997.

JOACHIM H. WITTOESCH, MD, FACS, Dayton, Medizinische Fakultät der Julius Maximilians Univ., Germany, 1949; age 74, died Dec. 17, 1997.

MAY B. ZAUGG, MD, Florida, Ohio State University College of Medicine, Columbus, OH, 1946; age 77; died Nov. 14, 1997.

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Theda Jessen

Capitol Dome Award from the American Cancer Society (ACS), Ohio Division, at its annual board meeting. The award honors excellence in advocacy.

Jessen, a member of the OSMA Alliance, has served at the local level as a board member of the Montgomery County ACS Unit since 1993 and has been the chair of the Tobacco Control Task Force since January 1995. At the division level, Jessen has been part of the Tobacco Control subcommittee since its inception in September 1994, serving as vice chair from January 1995 to January 1996.

Jessen is currently an active member of the division's Public Issues committee and grassroots network. She spends countless hours talking with and educating legislators, medical professionals and the general public on behalf of the American Cancer Society and its cancer control issues. She continues to be a committed volunteer, dedicated to the fight against cancer. ■

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Dr. 'Hutch' Williams dies in California

James Hutchinson Williams, MD, age 75, of Columbus, died Dec. 19, 1997, at the University of California Irvine Medical Center in Orange, California.



Many OSMA members will remember Dr. Williams (Hutch) as an active participant in organized medicine. He served as OSMA District 10 Councilor, a delegate and alternate delegate to the House of Delegates and chaired and served on several OSMA committees. He was also president of the Academy of Medicine of Columbus and Franklin County in 1975, and a member of the American Medical Association.

Dr. Williams received his medical degree from The Ohio State University, College of Medicine in 1946. After an internship and a year of internal medicine, he chose obstetrics and gynecology as his specialty. He completed his training in 1952.

After a two-year stint with the United States Army Medical Corps, he returned to Columbus.

Dr. Williams is most remembered for the four decades he devoted to medical education. He was promoted to professor of obstetrics and gynecology in 1970 and served as assistant and associate dean of student affairs at Ohio State from 1961-1988.

He remained at OSU until 1988, when he was asked to be associate dean of student affairs at the University of California at Irvine, where he retired again in 1992.

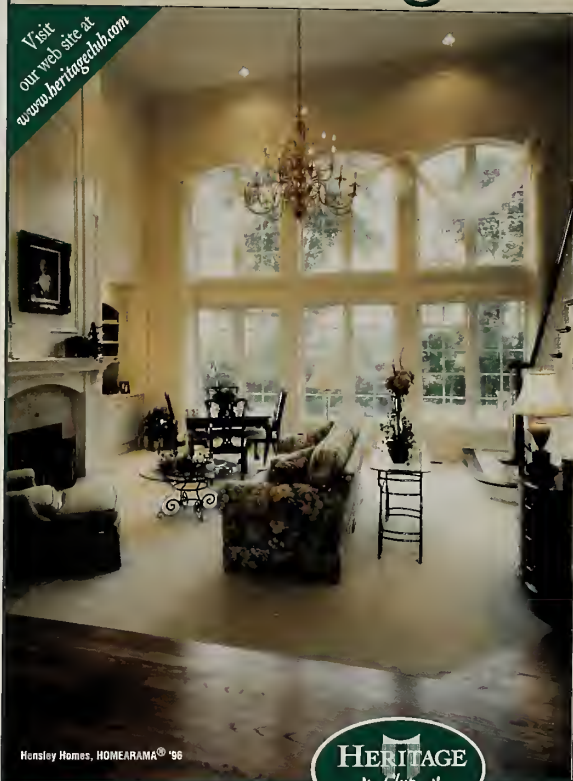
Some notable awards bestowed on Dr. Williams were: Otterbein College's Special Achievement Award in 1966; Ohio State College of Medicine Professor of the Year in 1969; Award of Gratitude from the College of Medicine class of 1979; the Appreciation Award from the class of 1979; the initiation of the J. Hutchinson Williams Scholarship Fund at Ohio State.

Dr. Williams is survived by his wife, Lucille, two sons and two daughters, and five grandchildren. ■

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Practice Tips

Physician executives earn more with degrees and risk

Physician executives: Want to maximize your earning potential?

The 1997 Physician Executive Compensation survey, completed recently by St. Louis-based Cejka and Company, a St. Louis-based health-care consulting and search firm and the American College of Physician Executives shows that:

• Advanced business degrees pay off.

Executives without post-graduate business degrees earned from \$160,000 to \$240,000 with the majority of respondents earning about \$190,000.

Meanwhile, doctors with Masters of Business Administration (MBA) degrees report incomes of \$166,000 to \$290,000, earning a median of \$200,000.

For physician executives with the more unusual Master of Medical Management (MMM) degree, income ranged from \$192,500 to \$240,000, with a median compensation of \$205,000.

• MBAs and other degrees provide an edge.

According to Roger Rathert, MD, director of Cejka Healthcare Executive Search Services, an MBA degree is less a job requirement than a "tie breaker" when two individuals are identically qualified.

• Experience still counts.

Only 22% of the physician executives responding to the survey had completed additional post-graduate business degrees. The usual track into the executive office is as follows: a physician spends 10-plus years in an organization and assumes the duties of a retiring medical director.

• Clinical duties diminish.

Physician execs are no longer dividing their responsibilities between clinical practice and management. Now, respondents say, 68% of their time is in management, 32% in clinical practice.

Those who spent the most time in management include: vice presidents of medical affairs (89%); chief operations officers (85%) and chief medical officers (79%).

• More primary care doctors are in management, but earn less than specialists in management.

The majority of survey respondents were specialists (55%), yet primary care physicians dominated the ranks of physician executives. Family practice physicians, internists and pediatricians accounted for 45% of the survey respondents. The greatest response was received from internists (19%) and family practice physicians (17%).

Still, primary care physician executives earned a median salary of \$175,000 versus a median salary of \$200,000 for specialty executives. Physician executives with the highest median salaries were: radiation oncologists (\$350,000), neurological surgeons (\$330,000) and cardiovascular surgeons (\$300,000).

• Single-specialty groups are more lucrative than government jobs.

Physician executives in single-specialty groups and practice management companies earned \$240,000. In government jobs, the pay was much lower, about \$126,000.

• Risks has its rewards.

Physician executives who earned a salary plus bonus typically earned more than executives who earned a straight

salary only. Survey respondents on salary brought in a median income of \$178,743; those on a salary-plus-bonus compensation earned a median of \$200,000.

And, the greater the risk the greater the reward. Executives whose bonus was less than 10% of their compensation earned \$182,000; those whose bonus is 41% or more earned a median compensation of \$300,000.



Practical tips:

In conclusion, Dr. Rathert offers the following tips for organizations and physician executive candidates to keep in mind:

- Remember that compensation is determined less by a physician executive's specialty than by the position.

- Be flexible. Physician executive positions are not determined by geographic area and only small regional gaps in physician executive compensation exist.

- Focus on experience, not academics. For most organizations, experience is still the most important qualification.

- Be prepared to make bonus a strong component of a total compensation package.

- Follow marketplace trends. The majority of physician executives now expect severance packages of six months to one year and, in some cases, even longer. This is particularly true in situations where physician executives are looking at a high degree of risk. ■

Problems with an HMO? Here's how to get their ear

If you're having problems with a Health Maintenance Organization (HMO), you don't have to handle it on your own. The OSMA can help — through its participation in the Ohio HMO Association (OHMOA) Provider Liaison program.

Here's what you need to do:

1. Contact the HMO plan and follow its internal procedures for resolving your concern. You may be able to achieve resolution without going any further. However, if your problem still remains unresolved, proceed to the next step.

2. Contact the OSMA Ombudsman office. The OHMOA has provided the Ombudsman staff with a resource list of all member plans including contact names, addresses and phone numbers. If the plan is a member of the OHMOA, the OSMA Ombudsman will know who to contact on your behalf. An attempt will be made by the Ombudsman and the OSMA contact to resolve the problem.

If the problem remains, and the OSMA Ombudsman office determines the concern has merit, the process moves to the next step.

3. Your concern will be forwarded, by the OSMA, in writing, to the OHMOA President. The written communication will document that the provider has pursued the HMO's internal channels of problem resolution and that the OSMA Ombudsman has not achieved resolution.

4. The OHMOA president will contact the involved HMO's delegate and CEO (if different) and inform them of the concern and the steps that have been taken to resolve it internally. The delegate and CEO will be responsible for handling the matter directly with the OSMA and/or the OSMA member.

The OHMOA president will track the issue with the involved plan on an informal basis.

You should keep in mind that, despite this program, the OHMOA has no ability or intention to attempt to force a plan to resolve a provider concern, and can not sanction member plans if no resolution is reached. ■

Take Action

To begin the process, contact the OSMA Ombudsman office, 1-800-766-6762 or e-mail: ombud@osmo.org.

Contract issues Arbitration: Who pays?

This column will discuss important points and language that physicians should be aware of before signing plan contracts. The OSMA also offers members a contract review service. For more information about this service, contact the OSMA Division of Legal Affairs at 1-(800) 766-6762.

When you see a provision in a managed-care contract that offers or requires an arbitration program to settle disputes, it should raise the following questions:

■ What rules will govern the arbitration?

Typically, the contract will specify either Ohio statutory provisions or American Arbitration Association provisions will govern the arbitration.

■ Who will pay for the arbitration?

Unless parties agree to other arrangements, most contracts split the arbitration costs between you and the other party. If that's the case, you'll pay a pro-rata share of the neutral arbitrator's fees and expenses and your attorney's fees and costs as well.

■ Will the decision be binding or nonbinding?

Most likely, it will be binding. Binding arbitration means only the procedural issues may be argued in court, not the amount of the award (unless the contract states otherwise.) If the decision is nonbinding, that means if a satisfactory resolution is not reached, the entire dispute can be taken to court.

■ Is there a mediation provision?

If the other party in the dispute is a managed-care entity rather than a patient, a mediation provision often asks both parties to outline their position to a neutral, trained mediator. The mediator will work with both parties to reach a mutually agreeable resolution to the problem.

Bottom line: Don't sign contracts with arbitration provisions until you:

- Understand who is responsible for the cost of the arbitration and how that cost is to be divided.

The contract should state clearly that you agree to submit disputes with plan members to arbitration. If the arbitration clause doesn't cover claims by plan members, this should be specified in the contract.

- Ask your professional liability insurer whether or not the arbitration provision conflicts with, or limits your existing coverage.

Contracts may indicate that you are not required to arbitrate a dispute if your carrier does not agree to the arbitration. Check it out before you sign.

Take Action

The information for this column comes from the Division of Legal Affairs and from "Book 2: Contracting Issues," which is part of the Navigating Change handbook series published by the OSMA. For information about ordering a copy of Book 2, contact Robin Parker, Division of Public Affairs at 1-(800) 766-6762, Ext. 216. ■

Ask the Legal Department

Q. Before it was pulled from the market, I prescribed the combination diet drug known as "fen-phen" for several of my patients. Now I've been told that I may have deviated from the standard of care by failing to tell these patients that prescribing fen-phen for weight loss was an off-label use of the drugs, and, as such, carried certain risks. Have I violated the tenets of standard of care or informed consent?

A. The doctrine of informed consent requires that physicians give patients sufficient information so that the patient can decide whether or not to undertake a proposed treatment or procedure. A physician must disclose the patient's diagnosis and the nature and purpose of a proposed treatment, including the reasonably known material risks and dangers of the treatment. A physician must disclose what a "reasonable person" would find significant in deciding whether or not to undergo the treatment.

Informed consent does not require that physicians discuss the regulatory status (i.e. the approved uses) of a drug. Physicians often prescribe drugs for off-label uses. As long as a drug can be legally sold for some purpose, doctors may use the drug in ways they believe, using professional judgment, will be in the patient's best interest. This includes uses not indicated on FDA labeling. Off-label use is governed by clinical and professional standards/standards of care.

However, there may be occasions where the patient should be informed of the FDA approval or nonapproval of a specific use of a drug. For example, a new experimental treatment with a particular drug might necessitate a discussion with the patient about the risks and benefits of the new, unapproved use. However, the well-established use of a drug for a non-approved use (such as sublingual nifedipine for hypertensive emergencies) might not require any discussion of the drug's regulatory status. ■

Take Action:

If you have a legal question you would like answered, please send it to *Ohio Medicine*, OSMA, 1500 Lake Shore Drive, Columbus, OH, 43204-3824, e-mail: ohiomed@osmo.org

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Avoid tax crunch with new software

TaxSolver for Business is a new software package that promises to save you time, and more importantly MONEY!

TaxSolver is the first program on the market to include every type of business tax return that will be needed by a small business owner. It could save you thousands of dollars on accounting fees, and costs only \$49.

Gregory Jackson, marketing director for ATX Forms, Inc., creators of the software, reports that 44,000 TaxSolver packages have already been sold.

Small businesses target

While this is the company's first attempt at targeting the small business owner, ATX Forms, Inc., of Washburn, Maine, has a long history of creating affordable and comprehensive tax software packages for corporations. "The time for the small business owner just seemed right," says Jackson.

Computer info available at Expo '98

Does the technology world have you baffled? If so, stop by the Academy of Medicine of Cincinnati's "Information Technology Expo '98" on March 7 at the Sharonville Convention Center.

Physicians and office staff are invited to stop by for an hour or spend the whole day. The daylong event, 7:45 a.m. to 2 p.m., gives you an opportunity to talk to exhibitors about hardware, software and information technology.

During the educational sessions, speakers will tell you what questions to ask and what you need to know before making your purchase. Speakers will address some of the latest trends such as: paperless offices, voice recognition software, computer security, information retrieval and education, and computer training via Web University.

Cost is \$20 for academy members and staff, and \$30 for nonmembers. Reservations must be made by Feb. 20 to the academy by calling (513) 421-7010. ■



Computer Chat

TaxSolver does just about every type of business return, plus a full-blown 1040. Plus, it includes a built-in spreadsheet program. "TaxSolver does all the calculations, you simply plug in the numbers," says Jackson. "It's like finding the Holy Grail," he adds.

Using dentists as their test-market group, ATX Forms, Inc. found that half of those surveyed filed an average of six different tax returns each year, everything from payroll quarterlies, corporate or partnership returns to retirement benefit plan tax returns.

For an additional \$29, you can also purchase a separate state program,

which includes business and personal returns.

Quick tutors are built-in

A five-minute tutorial on screen covers the basics of the program, and if you get confused there's a Quick Tutors built-in to give you easy show and tell directions. If that fails, you can call ATX's free tech support line at (207) 455-4848. The test-marketed group found TaxSolver an excellent program. Most said it was as easy to use as tax forms come.

TaxSolver is available on CD only and requires a 486 or better computer with a minimum of 8 MB RAM. It works with Windows 3.1 and 3.11; however, it is faster with Windows 95 and Windows NT.

To order TaxSolver for \$49 plus \$4.95 for shipping and handling, call 1-(800) 638-8291 or fax 1-(800) 285-5076, or check out their Web site at www.TaxSolver.com.

Also included is a 33-day money-back guarantee, if not completely satisfied. ■

For a list of what is included in the TaxSolver software package see story at right.

Pass on surety bonds for now

Surety bond companies are soliciting your business based on a little-known provision in the Balanced Budget Act. But you may not have to buy a bond at all.

If you're a Medicare provider who bills for durable medical equipment (DME) and supplies, you may have received letters from surety bond companies offering their services to you. They explain that the law now requires DME suppliers to have a surety bond.

Their statement is based on a provision in the federal government's Balanced Budget Act of 1997 that says all DME suppliers are required to have a surety bond of at least \$50,000 up to \$3 million for services furnished on or after Jan. 1, 1998.

Yet the law specifically states that these surety bond requirements do not apply to physicians and other health-care professionals.

The National Supplier Clearinghouse will send notices to suppliers who are affected by the law, detailing requirements regarding the bond. These notices will include the dollar amount of the bond required, the deadline for submitting the bond to the NSC and the time period to be covered by the bond.

The OSMA advises members who receive letters from bond companies to wait before responding. Unless you receive a notification from the NSC, chances are you won't have to buy a surety bond at all. ■

What's included?

TaxSolver includes the following returns.

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- 1120S Corporate
- 1065 Partnership
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Ohio Medicine

A publication of the Ohio State Medical Association

Court delays PIE liquidation

The Ohio Department of Insurance's (ODI) request for liquidation of the PIE company was continued until March 23. That will allow PIE's trustees time to hire outside consultants Coopers & Lybrand to assess the company's financial situation. If the consultants find that PIE needs to be liquidated, the trustees will no longer oppose the ODI's request.

A consortium of businesses, including Mutual Assurance, Ohio Hospital Insurance Company and others, are expected to present a proposal to ODI that requests the authority to take over PIE and run off its liabilities. The proposal must be submitted by March 23.

The 90-day stay that has been in effect since the ODI took over the operations of PIE will be continued for an additional 90 days.

PIE senior executives Larry Rogers, president and chief executive; James Marietta, chief financial officer; and Warren Udisky, chief legal counsel have agreed to a restraining order, prohibiting them from spending any of the \$11.5 million they received, allegedly without approval of PIE's board of trustees. They are to provide the department with an accounting of the funds as well as their current status.

Meanwhile, Steven L. Markowitz, MD, of Parma has filed a class-action lawsuit against the ODI, claiming the department halted a sale agreement between PIE and the Doctor's Company, a California-based medical malpractice carrier. The suit asks the state to pay insureds for losses that, in a combined amount, exceed \$25,000. ■

HCFA clarifies Medicare law

If a patient leaves a Medicare Risk Plan HMO for a procedure it's considered a noncovered service, even if it's a service covered by the HMO.

Physicians who are not contracting with Medicare Risk Plan HMOs may enter into private contracts with patients enrolled in Medicare Risk Plan HMOs, whether or not the plan covers the type of service the patient is seeking. Further, physicians may bill these patients their usual, customary charge instead of the Medicare allowable.

This is a new interpretation of the law, says Bill Fry, director of OSMA Ombudsman Services, who sought clarification on the law, recently, from the regional office of the Health Care Financing Administration (HCFA).

The federal Balanced Budget Act of 1997 (which took effect Jan. 1) allowed, for the first time, physicians to enter into private contracts with Medicare patients, but the rules are confusing. Here is what you need to know:

- If you treat a patient who is enrolled in Medicare, you may

enter into a private contract with that patient only if the patient agrees to pay for all services out-of-pocket, and only if you file an affidavit with the federal Department of Health and Human Services excluding yourself from the Medicare program for two years.

- If you treat a patient who is enrolled in a Medicare Risk Plan HMO, and that patient wishes to go outside the plan for a service, you may not only enter into a private contract with that patient (whether or not the HMO covers the service), but you may also charge that patient your full, customary amount, and not be required to exclude yourself from Medicare. ■

Take Action

This issue of private contracting remains complex, despite the recent clarification. If you have questions or need more information on this subject, contact Bill Fry, OSMA Ombudsman Services, 1-(800) 766-6762, Ext. 213.

Web site delivers news instantly

The OSMA Web site has been online since January, and if you haven't visited yet you're missing the latest health-care news in Ohio.

Here's what you'll find at www.osma.org:

- A hot news section with the latest news headlines. OSMA Calendar of Events will guide you to upcoming OSMA meetings, seminars, etc.

- The general information section explains what the OSMA is, what it does, and its mission statement.

- Legislation updates you on health-care bills introduced, recently passed and currently pending.

- Under membership information, is the OSMA store, services, benefits and information on OSMA sections.

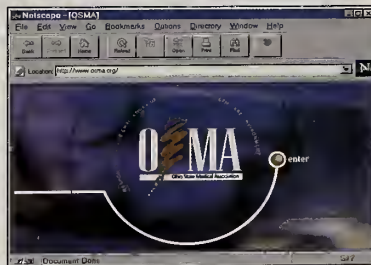
- The CME section is for members only. Locate various continuing medical education activities by location, date and/or activity.

- Members can hold conversations

with other members by posting a question on the bulletin board.

Finally, links connect you to other helpful Web sites.

If you have suggestions, contact Karen Kirk, 1-(800) 766-6762, Ext. 221, e-mail: ohiomed@osma.org. ■



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Bills, Laws & Rules

Debate finally begins over state trauma system

The long-awaited trauma bill, mandating a statewide trauma system, has finally been introduced. Rep. William Schuck (R-Columbus), the bill's sponsor, began to circulate drafts of the bill last fall.

The legislation calls for trauma victims to be taken to verified trauma centers rather than the nearest facility. Ohio has 18 verified trauma hospitals. In addition, the bill calls for pediatric trauma patients to be taken to pediatric trauma centers or to adult-care trauma centers with a pediatric commitment. The system would be eased in over two years and would be overseen by the Department of Public Safety and the Ohio Department of Health.

The governor supports the bill, however, nontrauma hospitals and other groups have resisted such legislation, including the 18-member Emergency Medical Services (EMS) Board which ignored its own Trauma Subcommittee's repeated requests for a mandatory, statewide system.

The bill will replace the EMS Board with a 13-member Trauma and Emergency Medical Services Board that

reports to the safety and health departments.

In addition, the legislation:

- Defines pediatric patients as 16 years old or younger.

- Requires that nontrauma hospitals create transfer protocols with trauma hospitals.

Trauma patients can be stabilized at a nontrauma hospital, but may not be admitted.

- Makes it illegal for nontrauma hospitals to bill themselves as trauma centers, and establishes fines for those nontrauma hospitals that designate themselves as trauma centers if they are not. Nontrauma hospitals that fail to transport patients to trauma centers would also be fined.

- Places the trauma registry, created in 1992 to track trauma patients from injury to rehabilitation, under the health and safety departments. Trauma data is due to be collected this year from every Ohio hospital.

Ohio Medicine will continue to follow this bill and report on its progress. ■



The statewide trauma system legislation introduced by Rep. William Schuck (R-Columbus) calls for trauma victims to be taken to verified trauma centers rather than the nearest facility.

Take Action

The OSMA Department of Legislation has prepared a white paper on the statewide trauma system bill. To order a copy, contact the Ohio Medicine reader response line and ask for Item 1-98. If you have questions about the bill, contact Maria Eshelman Bump, Department of Legislation, 1-(800) 766-6762, Ext. 222, e-mail: legis@osmo.org

Report briefs members on health bills

To keep members on top of the Ohio legislative scene, the OSMA Department of Legislation has prepared the following reports:

Position Paper on Managed-Care Accountability

An excellent resource on one of OSMA's legislative priorities for 1998. Included are provisions of House Bill 677 (the legislation supported by the OSMA), a discussion of "medical necessity" decisions, the financial impact of managed-care accountability and a review of how other states are addressing this issue. The paper would be especially helpful to PLAN members and other physicians who intend to contact their legislators to support this important bill.

1997-1998 Legislative Update

A succinct overview of the legislative accomplishments the OSMA made on your behalf in 1997, as well as a look at what the association hopes to accomplish in 1998. If you've wondered what the OSMA has done for you lately, you'll find the answer here. ■

Take Action

To order a copy of either or both publications, contact the Ohio Medicine reader response line 1-(800) 766-6762, Ext. 228 and ask for Item 5-98 (Position paper) and/or Item 6-98 (Legislative Update).

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A pain management course has been approved by the State Medical Board as required by law, but simply taking the course may not protect you if you've violated the board's pain management rules.

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Group practices with at least 10 physicians are now eligible to join the OSMA's Group Practice Section. Previously, groups needed at least 20 physicians to participate.



16

Reporting infectious disease is the best way to safeguard public health, so why aren't more physicians reporting the infectious diseases they see?



22

New prorated CME requirements have been approved. The requirements were necessary after the medical board decided to implement a staggered license renewal system.

Medical Board Report

Board OKs pain management course

The State Medical Board of Ohio has approved a continuing medical education (CME) course on pain management as required by the pain management legislation enacted last year. The board issued a caveat to its recommendation, however – a preamble to the law that sets the guidelines for intractable pain management.

"It is not feasible," says the preamble, "for the board to review all of the materials of a course, and board approval doesn't signify endorsement of all concepts and materials contained in the course. Practices that violate Section 4731.052 of the Revised Code (the part of the bill that provides the definition of intractable pain and establishes the rules for prescribing) or rules adopted thereunder do not gain legitimacy by virtue of having been taught in an approved course."

"In other words," says Kate Hunter of the OSMA's Division of Legal Affairs, "if the board believes that you are prescribing inappropriately for chronic pain, the fact that you have taken a pain management course approved by the board may or may not help you in your defense if you have deviated from the board's rules for the treatment of in-

tractable pain." The rules are currently being drafted.

The legislature gave the board a short timeframe to approve a pain management course, and board members have approved only one course at this time. The board's Pain Management Committee may approve other courses on this subject as they are developed. The courses must be certified by the OSMA and the Ohio Osteopathic Association.

The approved course is entitled "Intensive Course in Controlled Substance Management," and was submitted by Case Western Reserve University School of Medicine.

The OSMA's ad hoc committee on pain education continues to work on a pain management handbook to be distributed to all Ohio physicians this spring. The OSMA agreed to produce the handbook as part of legislative negotiations to drop mandated pain management CME from the bill. The handbook will offer two hours of Category I continuing medical education credit.

"We are also working with the State Medical Board on the development of rules regulating pain management," says Carol Mullinax, director of the Division of Public Affairs.

The board has drafted rules concerning pain management, but due to concerns expressed by the OSMA and others, including Rep. E.J. Thomas (R-Columbus), sponsor of the pain management bill, at a recent board meeting, the board voted to slow progress on the rules in order to allow more time for review and comment.

In addition to providing input on the pain management rules, the OSMA will also recommend a physician to serve on the board's new ad hoc committee to review the proposed rules.

Of note...

Prorated CME hours approved...

The board has approved a fact sheet that identifies the number of prorated CME hours required of physicians who are renewing their licenses in July 1998, when the staggered license renewal system will be implemented. A statement will now be included on the physician's wallet card that tells the licensee the number of hours of CME to be earned for renewal as well as the beginning and ending date of the time period in which CME must be earned.

Delegable medical tasks...A position paper has been drafted by the board's Physician Assistants (PA) Committee on what constitutes an appropriate, delegable medical task. The paper has been sent to interested parties for their input, including the OSMA. As soon as the paper becomes finalized, *Ohio Medicine* will provide information on its contents.

Impaired physicians and deselection...Members of the board's Managed-Care Committee are working with the Ohio Association of Health Plans (OAHP) to see how the removal of a physician's Drug Enforcement Administration (DEA) number for impairment reasons will affect his or her participation on a managed-care panel. The board is likely to comment to the OAHP that physicians should be assessed on an individual basis so that impaired physicians who have lost their DEA privileges due to self-prescribing and not inappropriate patient care, may continue to serve on managed-care panels. ■

Politics needs you

"All of our members need to be aware of the tremendous impact term limits can have on medical practice here in Ohio," says Steven P. Combs, MD, chair of the OSMA Committee on State Legislation. "As a result of term limits, about one-quarter of our legislature will turn over every two years. That means all of our efforts to educate these powerful lawmakers and the committees they serve on must be repeated more frequently and to more people."

New faces will have varying levels of expertise in health-care issues and many long-standing relationships, such as those with key committee chairs will end.

OSMA Political Affairs Coordinator Krista Bistline says: "Grassroots efforts to educate new legislators about health issues are effective and OSMA offers several ways to participate."

The Physician Legislative Action Network (PLAN), the OSMA's grassroots legislation initiative, faxes PLAN Alerts to members who want to make a difference. PLAN members are then asked to fax, phone or write their legislators in support of the OSMA position on a bill.

"OSMA staff will also set up a meeting and accompany any member on a visit when a legislator is in his or her home district," says Bistline. In the home district, OSMA and OSMA Alliance members may also wish to host legislative fundraisers.

"With legislators turning over so frequently, we'll need more members to help us present medicine's views to the Legislature," says Bistline. "Our grassroots PLAN program is now more important than ever." – Carol Larimer

Take Action

To become a member of PLAN, contact Krista Bistline, OSMA Department of Legislation, 1-(800) 766-6762, Ext. 223, e-mail: legis@osmo.org

Supreme Court decisions available on Web

Now that the Ohio Supreme Court is testing the constitutionality of the tort-reform law, this piece of news may be especially useful. You may now learn of Supreme Court opinions, rule amendments and other announcements immediately after they're released by accessing the World Wide Web.

And if you really want to

learn more about the inner workings of the state supreme court, the Web site also offers descriptions of the court's offices, biographies of the justices, a narrative on appeals courts and a diagram of Ohio's court system.

To reach the site, go to www.sconet.ohio.gov or you can access it through the "Links" section of the OSMA Web site, www.osma.org ■



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Assumed guilt: Bill placed physicians at risk

Until the OSMA became involved, physicians could have lost their licenses when indicted for (not convicted of) a crime, and would have lost the right to refuse an HIV test.

From the OSMA viewpoint, House Bill 606, as it was introduced by Rep. Kirk Schuring (R-Canton) on behalf of the State Medical Board of Ohio, left something to be desired.

The bill, in the House Health, Retirement and Aging Committee, revises the Medical Practices Act with regard to disciplinary, licensing and enforcement provisions.

The OSMA was concerned with two sections of the bill. The most onerous provision allowed the board to automatically suspend a physician's license if he or she is indicted for a felony, such as murder, felonious assault, kidnapping etc.

"This would have made physicians the only class of professionals whose license would be at risk before they are convicted of the crime," says Krista Bistline of the OSMA's Department of Legislation. "We think that's unfair and a violation of constitutional rights."

A second provision would have allowed the board to order a physician to have an HIV test if it believes the licensee has an HIV infection and has violated the Medical Practices Act.

The worst part of this section, says Bistline, is that consent for the test would not be required, and the physician was unable to elect to have an anonymous test if the test was ordered as part of a physical exam required by the board.

The OSMA sent a letter to the bill's sponsor, as well as to the board, taking issue with both of these provisions.

For example, with regard to the HIV test, the OSMA pointed out there is current law that says the physician has the right to consent to an HIV test as well as the right to an anonymous test. The OSMA questioned whether or not the board can override this statute, and believes the right to consent to an HIV test must be preserved.

With regard to the indictment language, the OSMA believed the provision was inappropriate and unconstitutional and says the board has failed to produce evidence that this type of action is necessary.

The OSMA met recently with the bill's sponsor, and the sponsor has agreed to modify those sections in accordance with the OSMA's requested changes.

"This is why it's important for organized medicine to be involved in legislation and why it's important for doctors to become members of the OSMA," says OSMA President-Elect Lance A. Talmage, MD. "If we didn't unite and speak out on bills such as this, we could have some bad laws." ■

Commission to examine health-care benefits

Should health insurers be mandated by legislation to cover certain health-care benefits? The Senate Insurance, Commerce and Labor Committee is considering a bill that would establish a commission to examine that question.

The bill, Senate Bill 209, was introduced by Sen. Karen Gillmor (R-Old Fort) before she resigned her legislative position. The measure is now under the sponsorship of committee chair Sen. Gary Suhadolnik (R-Strongsville). Supporters believe the bill is necessary because each session the Ohio Legislature receives a number of bills mandating coverage of certain health-care services. Some bills, like the drive-through delivery bill, have been passed; others, like Senate Bill 112, sponsored by Sen. Grace Drake (R-Solon), mandating coverage for diabetes education, are still pending.

A study commission would evaluate the social and financial impact of such legislation, and prepare an analysis of the bills.

Says Sen. Suhadolnik in a copy of the *Gongwer Report*: "We really need some way to take a hard look at each mandate beforehand. Maybe we need...a buffer to protect some legislators who feel undue pressure to support mandates that ultimately lead to higher health-care costs."

If SB 209 passes, the 11-member Mandated Health Benefits Review Commission would provide the buffer. ■

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Four bills now focus on MCO accountability

Another bill has been added to discussions on HMO accountability. House Bill 685 is the fourth managed-care accountability bill to enter the legislative arena this year, and it does so with 75 co-sponsors. The OSMA has expressed support for another bill, House Bill 677, which was introduced in January by Rep. Randall Gardner (R-Bowling Green) and Rep. Pat Tiberi (R-Columbus).

HB 685, sponsored by Rep. Jeff Jacobson (R-Dayton) holds health insuring corporations (HICs) liable if they fail to exercise care or delay in making a "medical necessity" decision. The bill also:

- Requires the Ohio Department of Insurance to prepare a brochure each year that enables members of the public to compare health-care plans.
- Makes utilization review (UR) for an enrollee's eligibility for health-care services available to an enrollee at his or her request.
- Requires HICs to consult with a "knowledgeable" physician with regard to UR.
- Requires the superintendent of insurance to review an enrollee's appeal of certain adverse coverage decisions.

Managed-care accountability is on the OSMA legislative agenda this year, and is likely to be a major focus at the Statehouse as well, once the school funding issue is settled.

In addition to HB 685, legislators will also consider this year:

- House Bill 677, sponsored by Rep. Randall Gardner (R-Bowling Green) and Rep. Pat Tiberi (R-Columbus). This bill, supported by the OSMA, establishes the accountability of MCOs that engage in negligent medical decision making that results in patient injury.

- Senate Bill 206, sponsored by Sen. Grace Drake (R-Solon), establishes, among other things, a grievance structure for enrollees as well as a managed-care ombudsman office at the Ohio Department of Health.

- House Bill 641, sponsored by Rep. Betty Sutton (R-Barberton), makes HMOs and other managed-care entities liable for the medical decisions they render.

Ohio Medicine will keep you updated on developments on this important legislative issue. ■

Take Action

To order a copy of the OSMA position paper on MCO accountability, contact the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 228, and ask for item 5-98.

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House Bill 392 seeks to set anesthesia standards

When the measure was modified, specialty-specific supervision was no longer required. The OSMa changed its position from "support" to "under advisement" as a result.

House Bill 392, the "quality in anesthesia" bill, would set guidelines for supervising Certified Registered Nurse Anesthetists (CRNAs). It also asks the State Medical Board to set rules regarding in-office administration of anesthesia, based on the board's May 1997 policy paper regarding in-office sedation.

The measure was drafted originally as a follow-up to the 1996 Advanced Practice Nurses (APN) bill, says Patty Davidson, MD, Chair of the Ohio Society of Anesthesiologists' Government Affairs Committee. That bill includes a requirement that APNs be supervised by physicians in the same specialty but did not specify supervision of nurse anesthetists.

Original bill made sense

Specialty-specific supervision "made a lot of sense to a lot of us," Dr. Davidson says. It assures that someone knowledgeable about current drugs and sedation procedures is monitoring the patient, resulting in better patient care. Also, current state law requires that CRNAs be supervised by a physician, dentist or podiatrist, provided the CRNA is not exceeding the scope of the dentist or podiatrist.

When HB 392 was introduced, it required supervision by an anesthesiologist in all cases involving sedation. However, the bill was modified in November following opposition from nonphysician members of the medical community, including dentists, podiatrists, nurse-anesthetists and the OHA: Association for Hospitals and Health Systems. The revised HB 392 stipu-

Specialty Concerns

lates that if an anesthesiologist is not available at the hospital, as may happen in small rural communities, the supervising physician, dentist, or podiatrist must be credentialed by the hospital as qualified to fulfill the supervisory role. The bill leaves credentialing standards up to the hospital.

This would apply in a very small number of cases, as 90% of the anesthesia in Ohio is administered by an anesthesiologist or care teams, including an anesthesiologist and CRNA, says Willa Ebersole. Ohio Society of Anesthesiologists' legislative representative.

OSMA changes position

However, that change prompted the OSMa Committee on State Legislation to recommend a change in the OSMa's position from "support" for the bill to "under advisement" which means that the OSMa will continue to monitor the bill. The OSMa Council voted in January to adopt the committee's recommendation.

The portion of HB 392 regarding rules for in-office use of anesthesia responds to continuing pressure from managed care to move procedures out of hospitals. "There are reports of many kinds of brave things being done in the office," Dr. Davidson says.

In addition, HB 392 would:

- Include definitions of conscious sedation, unconscious sedation and general anesthesia.
- Require that a separate, qualified person monitor a patient in any surgical procedure performed under general anesthesia.

This last requirement could be met by an anesthesiologist monitoring one

or two care teams utilizing CRNAs. The anesthesiologist, however, could not also be administering anesthesia while monitoring others.

Supervision won't raise costs

Supervision by an anesthesiologist will not raise costs, as some have suggested, Ebersole says, because anesthesia is billed by procedure. Also, it may ultimately reduce costs because the medical training and abilities of the anesthesiologist minimize the need for consultation by other physicians for medical or pain control decisions during recovery, for example.

The bill was assigned to the Health, Aging and Retirement Committee after it was introduced and at press time has had just one hearing.

Ohio Medicine will continue to follow this bill and report updates as they occur. — Anna Rzewnicki

ASA opposes HCFA rule

The American Society of Anesthesiologists (ASA) released a position statement opposing HCFA's proposed rule to eliminate physician supervision of nurse anesthetists.

On Dec. 19, 1997, the Health Care Financing Administration (HCFA) issued a notice of proposed rule-making by which it proposed to eliminate the long-standing federal requirement that nurse anesthetists be supervised by a physician in all approved hospitals and ambulatory surgical facilities.

Details on the ASA position statement can be found on its Web site at: www.asahq.org ■

Legal Review

Can you prescribe for yourself and/or family?

The State Medical Board of Ohio has found itself, lately, reviewing the cases of physicians who have prescribed for their family or for themselves, and have placed their careers in jeopardy as a result.

"There are several resources that doctors can refer to if they don't know what the guidelines are on this matter," says Kate Hunter of the OSMa Division of Legal Affairs.

One place that physicians can look for advice is the back of their medical licenses. The board also has a position paper on the subject of prescribing for self and family, and the AMA has an ethical opinion on the subject as well.

All of these guidelines discourage physicians from prescribing controlled substances for themselves or family members.

"If in an emergency or similar situation you do prescribe drugs to a family member, you should keep records," Hunter advises.

A recent case before the board involved a physician who had prescribed a large amount of a drug with some addiction potential for a family member. The board suspended his license for a period of time, in part because the physician had failed to keep adequate records. ■

Take Action

For a copy of the State Medical Board of Ohio's position paper on prescribing for family members, contact the board at 77 S. High Street, 17th Floor, Columbus, OH, 43215 (614) 466-3934. For a copy of the AMA's ethical opinion on prescribing for family, contact the Ohio Medicine reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item #7-98.

Dateline Ohio

Family health survey results will help Ohio assess program needs

The Ohio Department of Health (ODH) has hired the Gallup Organization to conduct the Ohio Family Health Survey. The telephone cluster survey will collect data about health insurance access, needs and satisfaction among 12,400 adults and 4,100 children throughout the state.

The telephone survey began Jan. 3 and will proceed until April. Preliminary results should be available in May.

"Survey results will hone our understanding of who is and isn't covered by adequate health insurance and why," says William D. Hayes, ODH Deputy Director for the Office of Policies, Planning and the Ohio Health Care Data Center. "The data will provide baseline and descriptive information that will help policymakers and planners better understand how changes in legislation and the marketplace affect Ohioans."

This is the first Ohio-specific comprehensive survey of its kind. Previously, reference information was interpreted from the federal census, other national surveys and insurance industry data.

In the past several years, the pace of marketplace health-care reforms has

quickened. Ohio is assessing how it administers public health-care programs and regulates the private health-care system, which will probably result in changes. Altogether, these factors have the potential to produce both intended and unintended consequences. However, according to Hayes, when the Ohio Family Health Survey results are analyzed, health-care reforms and outreach programs can be better designed for those in need without disrupting what might be working for others.

One example of the survey's immediate application is illustrated by the potentially significant changes facing Ohio's Medicaid system. The Medicaid program needs good information about how its population and its system compares to others. This survey will provide the first comprehensive data to allow such a comparison.

According to Hayes, another example of an outreach program that may be more closely tailored as a result of the survey is the Children's Health Insurance Program (CHIP), a federally-mandated program to expand health-care for children in families with little or no insurance. Survey-based recommendations will be delivered to the governor's CHIP Task Force by July 1.

In part, analysis of survey questions will describe uninsured individuals by age, race, gender, income and education levels, current employment and health status.

Additional questions will enable comparisons between uninsured, Medicaid-insured and commercially-insured Ohioans as to health status, access to care, utilization of services, satisfaction with care and unmet needs.

Analysis of the survey information will also assess relationships among behavioral risk factors, health-care utilization, health-care costs and general health.

Also, the survey will measure the extent of movement and reason for a change in coverage source within the past year. Coverage source changes may occur between employer-based plans, between uninsured and insured status, or involve Medicaid coverage.

While all Ohio counties will be sampled (about 62 households each), 22 counties were selected for oversampling. Some geographical areas and subpopulations were also chosen for oversampling, and they include the following: Appalachian; rural farm; inner city; industrial; metropolitan; African-Americans; Hispanics; Asian/Pacific Islanders; suburban commuters; Medicaid recipients; and uninsured persons. Under a related contract, the Cuyahoga County Center for Health Affairs will have an additional 800 households surveyed.

The survey is co-funded by the Department of Human Services, Medicaid Policy Section. — Carol Larimer

Doctors file lawsuits against PIE

Two federal lawsuits have been filed in Cincinnati against the PIE Mutual Insurance Company, reports the *Cincinnati Enquirer*.

Thomas A. Bender, MD, has filed a class action lawsuit in U.S. District Court that accuses the insurer of fraud, misrepresentation and deception, making policies sold by PIE worthless. Dr. Bender, a surgeon, seeks more than \$75,000 in damages, plus \$200 million in punitive damages.

The suit is also the first to charge misconduct against an insurance agency, Acordia/Rauh, licensed to sell PIE policies.

The second lawsuit, filed by Randolph C. Stinger, MD, and Tri-State Surgical Consultants, only names Acordia/Rauh as a defendant. W. Roger Fry, an attorney representing Dr. Stinger, told the *Cincinnati Enquirer* that "We purposefully did not name PIE because it is under rehabilitation orders involving a stay of all legal actions against the insurance company."

Dr. Stinger's suit seeks \$35 million in compensatory damages and unspecified punitive damages.

The suit alleges that Acordia/Rauh brokered PIE policies improperly, in view of the malpractice carrier's unstable financial condition. The suit also charges Acordia/Rauh of federal mail and wire fraud, and of failing to gain consent in canceling PIE policies and transferring them to the Doctor's Company.

The newspaper also reports that four additional suits have been filed against PIE in northern and central Ohio. One is a class action lawsuit, like the Cincinnati suits, and three are derivative suits on behalf of PIE stockholders. ■

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Hours: 1.0
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Sponsor: Robinsan Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: April 8
Time: 8-9 am
Hours: 1.0
Title: Extra Nodal Lymphoma
Where: Robinsan Memorial Hospital,
Ravenna
Sponsor: Robinsan Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: April 15
Time: 8-9 am
Hours: 1.0
Title: Melanoma
Where: Robinsan Memorial Hospital,
Ravenna
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Contact: Pat Dias, (330) 297-2540

Date: April 17-19
Hours: 17.5
Cost: \$200-\$375
Title: Esophageal Diseases
Where: Renaissance Cleveland Hotel,
Cleveland
Sponsor: Cleveland Clinic Foundation
Contact: Alyce Bell, (216) 444-5696

Date: April 20-22
Time: 8 am-noon
Hours: up to 12
Cost: \$345
Title: Clinical Update in Infectious
Diseases
Where: Sundial Beach Resort,
Sonibel Island, FL
Sponsor: University Hospitals, Cleve-
land
Contact: CME Registrar, (216) 844-
5050

Date: April 22
Time: 8-9 am
Hours: 1.0
Title: Lung Cancer
Where: Robinsan Memorial Hospital,
Ravenna

Sponsor: Robinsan Memorial Hospital
Contact: Pat Dias, (330) 297-2540

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OSMA News



Colleagues

Group Practice news

Section lowers numbers needed for eligibility

Medium group practices' need for representation and assistance prompted the Group Practice Section to recommend a bylaws change.

Group practices that have at least 10 physician members are now eligible to join the OSMA's Group Practice Section (GPS). Previously, groups needed at least 20 physicians to participate as section members. The OSMA Council approved the GPS bylaws change in late January at the request of the section. The GPS membership fee schedule and related administrative documents have been altered to reflect the bylaws change.

Joseph Flood, MD, GPS representative to Council, said that the number 20 was originally selected by the Group Practice Advisory Task Force because it is representative of the size at which political, economic and practice issues differ from smaller groups.

However, in determining to reduce

the size eligibility requirement for membership, the GPS Governance Committee took the following points under consideration:

- Current small group practices are likely to merge and become the large group practices of tomorrow.
- Group size is not constant. Because of the business dynamics of group practice, numbers vary frequently, sometimes on a monthly basis.
- Medium-sized groups are more likely to need the GPS than are larger groups which have more administrative representation and are more likely to have access to and/or membership in other organizations that serve the large group practice.
- The majority of requests for information and assistance (85%) have come from group practices of less than 20.
- The definition of "medical group practice" alienates groups of less than 20, not only from the GPS but from the OSMA as well.
- "The governance committee discussed and evaluated the need to change

the eligibility number and concluded that the number be reduced to 10 physicians for the next year," Dr. Flood wrote in his report to Council. During that time, staff will continue to research and evaluate the market trends for group practices.

Currently, the average size of group practices in Ohio is 10 physicians, reports Susan Rupli, director of OSMA's Group Practice Services. There are 72 large (more than 20) physician groups, representing 2,800 physicians. There are 776 groups with under 20 physicians, representing more than 4,000 physicians.

"We'll continue to visit groups out in the field and assess the trends in group practice," says Rupli. "Both the Medical Group Management Association and the AMA currently define group practices as physicians in practice with three members or more.

"However, because of the mergers taking place in group practices in Ohio, the governance committee decided not to lower the eligibility number any lower than 10."

That could change in the future, of course, if the research supports a further reduction in the eligibility requirements for the GPS.

Says Rupli, "The group practice dynamic changes rapidly and often. We'll just have to wait and see what future direction group practice takes before a decision like that is made." ■

Take Action

If you are interested in membership in the Group Practice Section or would like more information, and there are at least 10 physicians in your group, contact Susan Rupli, OSMA Group Practice Services, 1-(800) 766-6762, Ext. 102, e-mail: groups@osmo.org

JAMES CARR, MD, was honored at a public reception in November. Dr. Carr is finishing his 16th consecutive year as a Hamilton school board member. He did not seek re-election.

RICHARD FRATIANNI, MD, Cleveland, was reappointed to the State Board of Emergency Medical Services for a term ending Nov. 12, 2000. Dr. Fratianni is a physician with Metro Health Medical Center and an associate professor of surgery with Case Western Reserve University. The board prepares a plan for the statewide regulation of emergency medical services during times of disaster and establishes an emergency medical services grant program.

JOHN HINTON, MD, was named ChoiceCare/Humana new chief medical officer, responsible for overall medical management, pharmacy programs and clinical quality for Greater Cincinnati's largest managed-care plan. Dr. Hinton joined ChoiceCare in 1993 and was named senior medical director in 1995.

DAVID KESEK, MD, FACEP was re-elected to the International Basic Trauma Life Support board of directors in September for another three-year term and was also elected to the position of vice chair. Dr. Keské is president-elect for the Ohio Chapter of the American College of Emergency Physicians.

LINDA STONE, MD, Worthington, has been elected vice-chair of the Ohio Academy of Family Physicians Foundation. She currently serves as First Vice President of the OAFP. In addition to her duties as executive vice-president of the Medical Group of Ohio, Dr. Stone is active in all levels of organized medicine.

Seminar offers tips on buying, merging practice

If you're thinking of buying, selling or merging a medical practice, plan on attending the OSMA Group Practice Section's educational program March 6 from 10 a.m. to 2 p.m. at the Concourse Hotel in Columbus.

Topics to be discussed include:

- Expected trends in medical group mergers
- Working with the experts to make your practice merger successful
- Making the decisions to buy/sell/merge your practice

A member of the OSMA's Legislation Department will give an update on current legislative issues.

This is an ideal opportunity for administrative and physician leaders in group practice to interact with colleagues to discuss these and other important issues that affect your practice.

For more information, contact Susan Rupli, OSMA Group Practice Section, at 1-(800) 766-6762, Ext. 102. ■

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• Successfully completed a two-year campaign to achieve significant managed-care reform in Ohio?

These are only a few of the accomplishments the OSMA achieved during 1997. There are many more.

To order a copy of the annual report contact the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item 2-98 or check it out on OSMA's Web site at www.osma.org.

"We believe we are meeting the challenge, but only you...can evaluate our effectiveness," the report's overview states. This is your opportunity to see the value of your dues dollars.

• Handbook describes how to make the most of membership

How do you make the most of your membership in the OSMA?

One way is to familiarize yourself with benefits and services the OSMA provides.

Making the Most of Your OSMA Membership is a comprehensive handbook that lists all of the advantages of an OSMA membership. An OSMA staff services directory divided by subject is also included so you will know where to direct your questions.

New members will receive a copy of the handbook automatically, but you may order your own copy by contacting the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 228, and ask for Item 3-98. ■

County medical society news

First osteopathic president leads Toledo membership

Lucas County

For the first time in the 141 year history of the Academy of Medicine of Toledo and Lucas County, a doctor of osteopathy has been named president. Donald B. Marshall, DO, family practice, was installed at the society's annual meeting on Jan. 14. Dr. Marshall has also held the office of president of the Toledo Academy of Osteopathic Physicians and Surgeons. Other officers elected include: president-elect: S. Amjad Hussain, MD, thoracic and vascular surgery; vice president: Mary J. Gombash, MD, emergency medicine; secretary: Philip C. Stiff, Jr., MD, internal medicine/cardiologist.

Keynote speaker and OSMA President Su-Pa Kang, MD, and Patrick McCormick, MD, took advantage of an attentive audience to tout the benefits of OMPAC participation.



Su-Po Kong, MD, president of the OSMA, (left) explains the benefits of the Ohio Medical Political Action Committee (OMPAC) to prospective member Thomas Klever, MD, of the Academy of Medicine of Toledo and Lucas County's Annual Meeting. (Photo courtesy of Academy of Medicine Toledo and Lucas County.)

Franklin County

Nearly \$400,000 dollars was awarded to six organizations from the Columbus Medical Association Foundation.

"We are excited about these projects and are committed to building and strengthening the partnerships critical to their services," said CMA Foundation Grants Committee Chair Claire V. Wolfe, MD. "Our hope is that more organizations begin to view the foundation not only as a financial resource, but as an integral part of the process to find better ways to address Central Ohio's public health concerns." Grant recipients were:

- Children's Defense Fund Ohio (\$95,000) Medicaid/CHIP Enrollment Demonstration
- Children's Hospital (\$82,408) Use of pediatric primary care visit to initiate smoking cessation therapy for families
- Columbus Health Department (\$48,760) Columbus Neighborhood Health Center, Inc., Network Project
- Communities in schools Columbus (\$30,000) Medical Student Outreach II
- Heritage Day Health Centers (\$88,049) Occupational therapy for independent living
- Southside Mission Project, Inc. (\$50,695) Safety and Health Outreach Worker Program (SHOW) ■

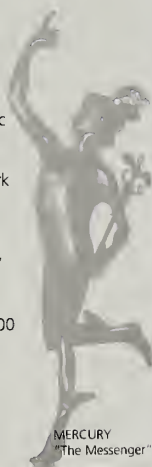
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President's Perspectives

Expanded scopes not good for the public or medicine

Nurses, pharmacists and other allied health-care practitioners are vital players on the health-care team. Working together, we can maximize patient care.

But throughout my career in medicine, there has been a disturbing movement among some allied practitioners that causes concern among most physicians. I'm talking about

legislative initiatives by these groups to expand their scopes of practice.

While physicians have no quarrel with health-care practitioners seeking to increase their bases of knowl-

edge, most are concerned when this effort involves attempts to, in effect, become physicians.

Senate Bill 66, Pharmacy Practices, sponsored by Sen. Grace Drake (R-Solon) has passed the Ohio Senate and is now pending before the House Health Committee. As originally introduced, the bill would have granted pharmacists the right to prescribe medication and perform certain activities that have traditionally been considered the practice of medicine. The OSMA worked closely with the sponsor to remove the most onerous parts of the bill before it passed the Senate. As it is currently drafted, the bill would allow pharmacists, in consultation with physicians, to modify prescriptions on a patient-specific, disease-specific basis. While still concerned about the consequences of this legislation, the OSMA believes that this bill will likely pass the House this year.

The nurses are also before the

Legislature this year. HB 667, Advanced Practice Nurse Prescribing Authority, sponsored by Rep. Rick Hodges (R-Wauseon) is currently pending in the House Health Committee. It will allow Advanced Practice Nurses to prescribe, in collaboration with a physician. The OSMA has long-standing House of Delegates policy opposing granting APNs prescriptive authority. In 1996, the APNs made a similar legislative push but the OSMA was successful in its efforts to amend this bill before it became law. In 1993 a law was enacted that granted prescribing rights to APNs in several pilot projects around the state. These pilot projects were mandated to report back to the Legislature before additional prescribing rights were granted. However, the reports that have been issued thus far do not contain sufficient data to make any determination regarding how well these pilot projects are working.

The OSMA believes that legislative initiatives described here, plus the many other attempts over the past 20 years by allied practitioners to expand their scopes of practice, are not good for the public and they are not good for medicine. The OSMA will continue to oppose these bills. But, in reality, the OSMA deals with more than 150 bills each legislative session. Allied practitioners often have only one issue each session — bills to expand their scopes of practice. To continue to be successful, we need your help in contacting legislators on these issues and in educating other physicians.

Working together, we can make a difference. ■



Su-Pa Kang, MD

OSMA dissatisfied with Aetna response

Aetna/US Healthcare has told the OSMA that it will continue to negotiate with providers on contracts, but it did not say how long beyond the Dec. 31, 1997 deadline it would negotiate, nor did the carrier state that it will make any changes in its present contract.

The OSMA as well as the American Medical Association has expressed concerns to Aetna about its contracts, especially a provision that gives the carrier the right to unilaterally change patient care procedures and policies. Also at issue is the carrier's lack of cooperation when providers wish to negotiate their contracts. "The doctor has to sign the contract or not sign it," says Nancy Gillette, JD, OSMA legal counsel. "It's an all-or-nothing approach."

In a report to OSMA Councilors in late January, Katrina English, JD, director of OSMA's Division of Legal Affairs, reported that Aetna will negotiate with some providers beyond the deadline, but there was no clear indication that the deadline had been extended, a point the OSMA is trying to clarify.

"We requested that Aetna negotiate fairly with providers, yet Aetna failed to respond to our requests, stating it was prohibited from doing so by antitrust concerns," says English. ■

Take Action

Aetna/US Healthcare has prepared a statement on provider contracts, which is in response to the AMA's letter of concern on this subject. If you'd like a copy of this statement, contact the Ohio Medicine reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item 4-98. The OSMA also offers members a contract review service through its Division of Legal Affairs, and those who use this service receive notice of the problems present in Aetna contracts. For more information, contact Kate Hunter, OSMA Division of Legal Affairs, 1-(800) 766-6762, Ext. 129.

Recruitment, Employment and Partnership Contracts; Hospital Bylaws, Credentialing and Privilege Issues; Medicare Fraud and Abuse Matters; High Risk or Uninsured Malpractice Exposures; Joint Venture Arrangements; Medicare, Medicaid and PRO (PRS, Inc.) Audits; State Medical Board Actions, Etc.

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Practice Tips

Public Health

How to report infectious diseases

Prompt reporting of infectious disease cases is key toward identification and control of possible public health problems, says Tom Halpin, MD, one of five epidemiology supervisors at the Ohio Department of Health's (ODH) Bureau of Infectious Disease Control. It's also a state law. Yet many cases are not reported, he says, because of time constraints at physicians' offices, or because the physician doesn't know what diseases to report or which local health department to call. Some physicians call the ODH directly regarding possibly related infectious disease cases, so the ODH recently designated one phone line (614) 466-0265 as a reporting desk.

However, the state staff usu-

ally depends on local records to identify and act on disease trends, which is why it's important for physicians to work closely with their local health departments and make initial reports there, says Dr. Halpin. (See "Take Action" to order a directory of local health departments.)

Reportable diseases

Ohio has three classes of infectious disease that must be reported.

An Emerging Infection Committee meets several times a year to review the Class A listing, adding and deleting diseases as necessary. VRE and invasive strep were among the diseases added last year.

Cases involving Class A diseases should be reported locally within 24 hours of identification. This class includes 33 diseases considered to be major public health concerns, such as hepatitis and all the vaccine-preventable diseases, invasive streptococcus pneumoniae infections, vancomycin-resistant enterococci (VRE) and other emerging diseases; sexually transmitted diseases and enteric diseases.

An Emerging Infection Committee meets several times a year to review the Class A listing, adding and deleting diseases as necessary. VRE and invasive strep were among the diseases added last year, Dr. Halpin notes.

Also included in Class A are 33 low-frequency diseases such as botulism, cholera, malaria and plague.

The Ohio Administrative Code provides a complete listing of Class A diseases. It's available by calling the ODH reporting desk.

Included in Class A disease reports are the name of the disease; patient demographics, including date of disease onset; the physician's name and ad-

dress; and date of the report. Reports can be made by phone or by using a form available from the local or state health departments.

Looking for connections

"The 24-hour time line is the key in contacting local health departments" where initial follow-up work is done, Dr. Halpin says.

Local reports are compiled and submitted daily to the ODH. The department's staff continue the investigation, verifying diagnosis, matching physician reports to lab reports and identifying trends.

Reporting is also required for two other classes of diseases:

- Class B diseases,

such as influenza or chicken pox, are reported by number of incidents only, on a weekly basis.

- Class C diseases are reported only when an epidemic is suspected, as is possible with food-borne diseases, head lice and scabies.

The ODH forwards weekly statistical reports for 52 selected diseases to the Centers for Disease Control (CDC), which publishes summary data in its "Morbidity and Mortality Week Report," released nationally each Friday.

ODH also publishes county-by-county data in *Prevention Monthly* and its Annual Summary of Infectious Diseases. — Anna Rzewnicki

Take Action

To order a copy of the directory of the state's 144 local health departments, health commissioners and medical directors, call the ODH's Bureau of Local Services, (614) 466-2205.

Streamlining the reporting system

Local health departments in northeast Ohio have taken steps toward streamlining infectious disease reporting and improving case tracking efforts.

"People have always recognized that there is a severe underreporting" of infectious diseases, says Terry Allan, supervisor of the environmental division at the Cuyahoga County Department of Health.

"The difficulty has to do with the public health system in Ohio. We have more than 120 health departments, including five in one county, Cuyahoga, that serve the suburbs, small cities and Cleveland. So if you are a doctor with a case of salmonellosis, you can get tired of trying to reach the correct office," he says. This confounds local and state efforts to track and control the spread of diseases within a population.

Infectious control officials in the northeast counties began working together last June after noticing the growth of mosquito-borne diseases in the region.

"We decided to bring together all the health departments that were interested and work together," Allan says. Joining were the health departments of Cuyahoga, Lorain, Lake, Geauga, Portage, Summit, Medina, Mahoning, Wayne and Ashtabula counties, as well as those of numerous municipalities. They've since moved from the mosquito to issue to infectious disease reporting.

A pilot project, now under way in Summit County, gives area physicians one central phone number and a common form for reporting infectious disease cases that would otherwise be submitted to either the Summit County, Akron or Barberton health departments.

"The Akron Health Department is tracking the diseases (from the three population areas). As cases come in, they are forwarded to the individual health departments for further investigation," Allan says.

The consortium is now considering a toll-free reporting number that all physicians in the region could use. The ideal, Allan says, would be to have four continued on page 17

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Diseases...

continued from page 16

regional toll-free numbers serving the state, with all reporting completed electronically.

The ODH is studying this concept, says Robert French, one of the state epidemiology supervisors. However, the state department does not have the resources to establish a statewide system, he says, and not all local offices have the computer capabilities needed to support such an effort.

Consortium members have been asked to report on their efforts at the Association of Ohio Health Commissioners' meeting this fall. — Anna Rzewnicki

Government won't pay loan defaulters

The federal government has taken two new steps to collect student loans from health-care professionals, including physicians, who continue to default on their payments despite various attempts by the government to collect.

Now, defaulters will not receive reimbursement for any services they render to Medicare and Medicaid and their names will be released to the public.

Defaulters make up only 5% of the more than 100,000 health-care profession students who have received loans since 1979 when the program began. However, those approximately 1,400 physicians and other professionals owe more than \$107 million to taxpayers.

Physicians who may belong to this small group of student loan defaulters should contact the U.S. Health Resources and Services Administration, which oversees the student loan program, and make a good-faith effort to repay the loans.

A recent check indicates that eight Ohio physicians are in arrears, however none are OSMA members. ■

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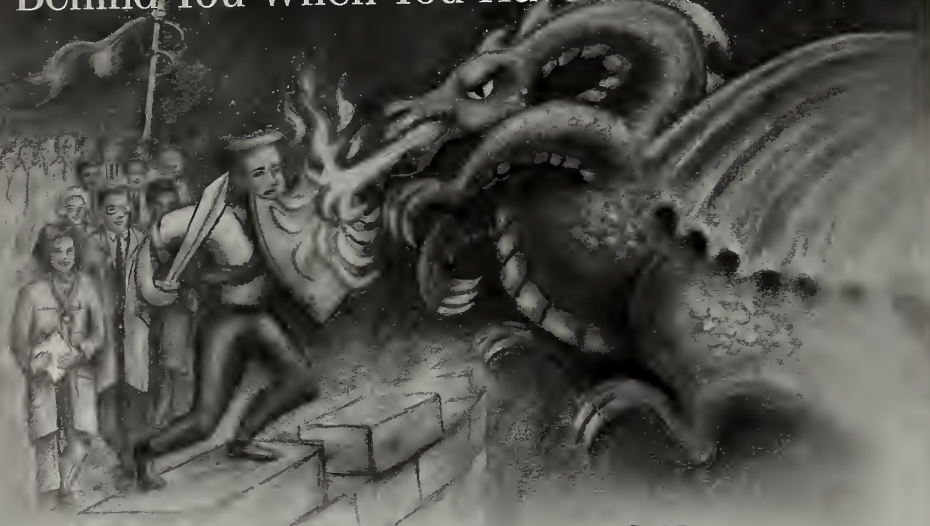
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Videotapes of a satellite video conference, held last November by Hepatitis Foundation International and the Centers for Disease Control, focuses on the latest developments in the epidemiology, diagnosis, clinical management and prevention of Hepatitis C. The cost of the videotape and reference test is \$15. A two-hour audiocassette tape with key discussions from the conference is \$10. To order, call Hepatitis Foundation International, 1-(800) 891-0707.

Ohio Health Promotion Clearinghouse

Educational health-promotion resources on a variety of topics are available through this service of the Ohio Department of Health. Included are: annotated bibliographies of educational materials, journal articles and programs; an ODH audiovisual library; and an educational material loan-by-mail service. New to the library is the CD-ROM based InfoTrac Health Reference Center that can provide current, health-related information from 165 core health journals and newsletters. Contact the Ohio Health Promotion Clearinghouse, Bureau of Health Promotion and Risk Reduction, Ohio Department of Health, P.O. Box 118, Columbus, Ohio 43266-0118, (614) 466-4626. ■

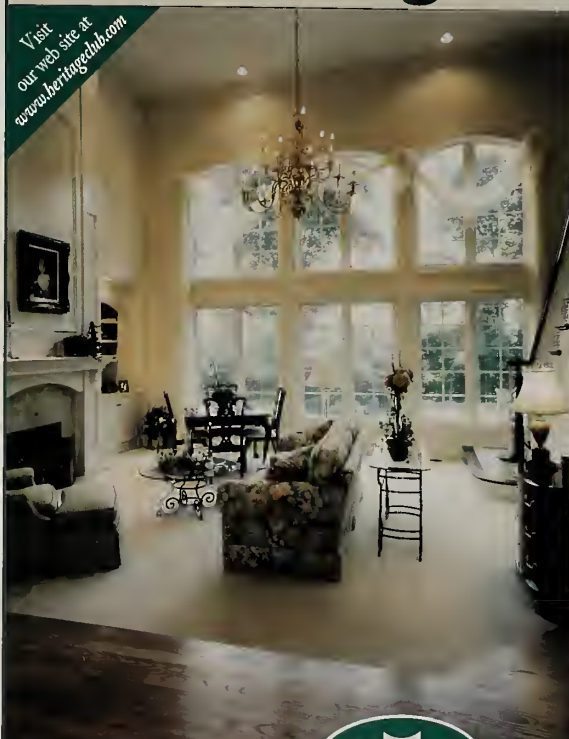
PBS special addresses addiction

A special PBS five-part series called *Moyers on Addiction: Close to Home* will air for three consecutive nights on PBS stations beginning March 29th at 9 p.m. The series will be supported by a Web site at www.pbs.org. This series will reveal the science, treatment, prevention and politics of addiction, as well as detail the progress of new medical techniques and changing public attitude. A video set is available for \$299. To order, call 1-(800) 257-5126. ■

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My favorite Web site...

Daniel W. van Heeckeren, MD

Editor's note: This new column will help you navigate to sites, medical and non-medical, favored by OSMA members.

www.sts.org

"This is the Web site for the Society of Thoracic Surgeons, and it has a number of features that help keep members up-to-date on news in our specialty. I especially like the link to STS publications, which can provide direct access to articles and the political awareness section that provides information on legislation. There is also a special section on the site that continues to follow active discussions on the practice component of the RBRVS. Very timely."

What to look for: Sections on the site include: What's New, Outcomes and Databases, Health Policy, HCFA RVU Crisis, STS Information and Discussion Forums. The "STS Information" section links you to newsletters, events, committees and members of the society. Members may submit photos to run with their member profiles if they wish. "What's New" links you to articles from the Annals of Thoracic Surgery. You can choose to read the full text or "Editor's Highlights." Site visitors can also participate in online discussions about the articles. The "HCFA RVU Crisis" provides regular updates on what the STS and the AMA are doing with regard to HCFA's intent to regulate changes to practice expense values.



Dr. van Heeckeren

www.whitbread.com

"If you like to sail – and even if you don't – this site offers a fascinating glimpse at an around-the-world sailboat race, hosted by Whitbread, a brewing company. The site provides updates every six hours. There are maps to follow, weather conditions are posted regularly, and you can even participate in discussions with some of the shipboard crews. It's an excellent use of electronic technology. Satellites provide the site with the newest locations of the racers and we're updated so frequently that it's almost like being part of the race."

What to look for: Officially the race is known as the "Whitbread Round the World Race for the Volvo Trophy," and 10 Whitbread "60" boats are participating. The race will take nine months, visit nine ports and finish where it started, in Southampton, England. The site provides visitors with daily e-mail, video, photos from boats, news stories, and audio interviews with skippers. "Everything but the frozen air and soaked sleeping bags." The site receives 9 million hits per day and claims 920,000 users.

Take Action

Do you have a favorite Web site you would like to share with Ohio Medicine readers? Contact Koren Edwards, 1-(800) 766-6762, Ext. 232, e-mail: ohioned@osmo.org

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OSMA, BWC work to ease managed-care

If you're involved with the Bureau of Workers' Compensation's (BWC) Health Partnership Program (HPP), you're already aware of some of the problems that have arisen with the implementation of managed care into the BWC system: Payments are often late; bills are incomplete; MCO practices are not standardized; and providers aren't always given the status reports they need.

The BWC is aware of the roadblocks in its new program and has formed an Administrative Simplification Work Group to address the hassles and confusion. The OSMA is an active participant in that group, and has made recommendations to the BWC that will help ease the process for providers. The BWC is implementing each of the following suggestions:

Development of a provider grid.

This grid will outline the HPP injury reporting process, as well as the bill payment process. Identified as the "Provider Tasks and Timeline Chart," the grid has been completed and was distributed to all participating physicians in the most recent 1998 BWC Billing and Reimbursement Manual Update. The purpose of the grid is to make both providers and MCOs aware of the tasks and responsibilities required of all parties involved in the processing of a workers' compensation claim.

New treatment plan form.

A new two-page standardized treatment plan form has been developed to promote more consistent and accurate reports for treatment. The new C-9 form replaces the C-1-A and C-161 forms and was distributed in the Billing and Reimbursement Manual Update.

Toll-free line for providers.

The BWC has expanded the information available to providers via the BWC's toll-free telephone system. Physicians may call 1-(800) 644-6292 and choose option 41 to obtain information

regarding a claim number and status of a claim, ICD codes and whether a particular code will be approved for payment, the MCO responsible for the claim, and, in the near future, expanded information regarding bill status. Physicians may call the same number and choose option 42 to register specific complaints regarding a Managed-Care Organization.

HPP report card.

The BWC is finalizing an MCO report card to be sent all employers during the 1998 Open Enrollment period (April 1 - May 29). The Report Card will contain information on each MCO for each of the following categories: FROI timing, customer satisfaction, return to work rate, and an overall "grade." The OSMA has strongly suggested that in the future physician input be gathered as well, and has sent a letter to the BWC requesting that provider opinion be included in the report card process.

The OSMA Task Force on Workers' Compensation continues to monitor the implementation of HPP, and will assist in preparing a report on the new managed-care system that will be given to the OSMA House of Delegates in May.

Patrick McCormick, MD, task force chair, also continues his involvement with the BWC Health Care Quality Advisory committee. Watch future issues of *Ohio Medicine* for reports on that group's activities. ■

Take Action

Members who are experiencing problems with the BWC's Health Partnership Program can visit the OSMA's Web site and complete a survey online, or you may send your problems, in writing, to Nancy Gillette, OSMA Division of Legal Affairs, 1500 Lake Shore Drive, Columbus, Ohio 43204. These will be collected and forwarded to the BWC for a response.

Contract issues

Referral provisions: Know the players

Most managed-care plan contracts will contain a provision or two that requires you to refer your patients to "participating plan providers," unless, of course, there is an emergency.

But referral provisions may actually be more complex, requiring a careful reading. Here are a few of the trouble spots to watch out for:

■ Vague language

Contracts may require you to refer to "participating providers" — a term so broad you may be unaware that, in addition to referring to necessary specialists, the plan also expects you to refer patients to labs, physical therapy facilities and other ancillary service providers in the network. If you fail to do so, the plan may deduct the amount owed to the referral provider from your reimbursement.

When negotiating: Ask the plan to be more specific about the types of providers you will be expected to refer patients. Ask if you will be expected to refer patients to preferred providers of ancillary services.

■ Service provider exclusivity

Referral to network service providers may be worded in such a way that you are discouraged from providing any of these same services in your office, although you may have done so for some time, and may still provide these services to non-network patients. In some cases, however, the contract will state that you will not be reimbursed for any in-office service you provide.

When negotiating: If you provide in-office services, ask the plan if you may continue to provide in-office service to network patients, or if you will have to refer them to outside service providers.

■ Provider lists

You may not rely on the fact that just because a provider is on the plan's panel he or she is a competent physician. You may be held liable for a negligent referral if

you refer your patient to a physician on a managed-care panel without first making some effort to ascertain that provider's competence.

When negotiating: Be sure you ask for a current list of providers and review the list carefully to determine how your current referral practice will be affected and how comfortable you will be referring your patients to the providers on the list. If you don't know the providers, make an effort to determine their qualifications and level of competence before you refer your patients.

■ Restricted referrals

Some contracts will contain provisions that require you to refer only to providers that participate in the plan. As stated above, you must make yourself aware of the physician's competence before you refer your patients. Be aware that some plans, in an effort to contain costs, limit the physicians or facilities on their panels.

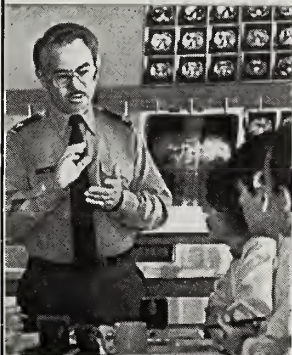
When negotiating: Before you sign with the plan, make sure that they have an adequate referral list so your patients won't have to wait an unnecessarily long time for medical care if you refer them. Also, be sure that the contract contains an exception to this restriction for emergency circumstances or circumstances where quality care considerations require referral outside of the network.

■ Out-of-plan referrals

Inquire about the procedures to be followed for an out-of-plan referral should one become necessary for out-of-network care. Does the plan offer a point-of-service option? What effect will a referral to an out-of-network provider have upon your reimbursement?

When negotiating: Make certain you understand all of the ramifications if you refer a patient outside of the plan's network. It's also wise to make certain your patients understand any financial obligations they assume if you refer to noncontracting hospitals or physicians. ■

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Beware of yellow page solicitation

Cincinnati Medicine reports that some physicians have been confused by a company soliciting yellow pages' advertising that is not affiliated with Cincinnati Bell.

According to the report, RH Donnelly, a New York-based firm, is soliciting ads for a new yellow pages' publication that it is trying to start locally, but it is not affiliated with the Cincinnati Bell yellow pages. Cincinnati Bell used to contract with RH Donnelly, but has made the Berry Company its new sales partner.

Because of the variety of yellow pages now being published, it would be wise for all physicians to exercise caution before buying any yellow pages ad.

Check first to see who the company soliciting your advertising represents, and in what directory your ad will appear. ■

Ask the Legal Department

Q. Several of my patients have brought me copies of their living wills. What are my legal and ethical responsibilities toward my patients now that I have these documents? Am I supposed to keep the living wills in my office, or are the patients supposed to file them with the Clerk of Courts office in our county?

A. Advance directives are legal documents that state a patient's desires regarding medical treatment should the patient be incapacitated. A living will is a patient's declaration of his or her wishes regarding life-sustaining treatment if the patient is terminally ill or permanently unconscious. Living wills apply only to decisions regarding life-sustaining treatment and only when a person is diagnosed as terminally ill or permanently unconscious. A durable power of attorney for health care (DPAHC) is a broader, more flexible document that authorizes a designated person (an attorney-in-fact) to make health-care decisions on behalf of the patient at any time the patient is unable to make those decisions. A DPAHC may be used when the patient is temporarily or permanently incapacitated and unable to consent to treatment.

If a physician is aware that a patient has executed a living will or a DPAHC, the physician is legally and ethically obligated to render treatment in accordance with the wishes of the patient as stated in the documents. Ohio law gives physicians certain immunity from liability for actions or decisions made when implementing an advance directive. However, there are procedural requirements that must be followed. For example, in the case of living wills, two physicians must diagnose the patient as terminal or permanently unconscious, document the diagnosis and notify family members before carrying out a patient's directives. In the case of a DPAHC, the physician must determine and document that the patient has lost the capacity to make health-care decisions and must determine that the DPAHC is valid and that the attorney-in-fact is authorized to make health-care decisions for the patient. As a general rule, health-care decisions made pursuant to a DPAHC must be consistent with the patient's wishes, and if the wishes of the patient are not known, the decision must be consistent with the patient's best interest.

Advance directives help patients only when health-care providers know the documents exist. Patients should be ad-

vised to give copies of current advance directives to their physician, lawyer and family members or loved ones. It's appropriate for physicians to keep copies of advance directives with a patient's chart and document in the chart that a patient has executed an advance directive. Ohio law now gives patients an option of filing advance directives with their county Clerk of Courts office. The filing creates a public record that can be accessed by a hospital or other care provider (or anyone else) to determine if an individual has an advance directive as well as its contents. However, not all individuals will choose to make their advance directives public information. The best course of action for physicians is to communicate with patients regarding advance directives, discuss the choices available to the patient, and document when a patient has completed or revoked an advance directive. ■

Take Action

If you have a legal question you would like answered, please send it to *Ohio Medicine*, OSMa, 1500 Lake Shore Drive, Columbus, OH 43204-3824, e-mail: ohiomed@osmo.org

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Board OKs CME requirements for staggered license renewals

The State Medical Board of Ohio has finally released its new continuing medical education (CME) requirements for its staggered license renewal system.

For the initial renewal, CME hours will be prorated in proportion to the length of time the license is valid. The physician's renewal group will be based on the first letter of his or her last name at the time the staggered renewal is implemented. After that, the licensee will remain in the originally assigned group.

The dates of each physician's renewal cycle will be printed on the Ohio license wallet card.

At right is the new revised CME cycle and the changes in the number of CME hours required. ■

New CME Requirements

First Initial, Last Name	CME Period	Hours Needed
A-B	7/1/98-4/1/2001	137 hrs. (55 Category I)
C-D	7/1/98-1/1/2001	125 hrs. (50 Category I)
E-G	7/1/98-10/1/2000	112 hrs. (45 Category I)
H-K	7/1/98-7/1/2000	100 hrs. (40 Category I)
L-M	7/1/98-4/1/2000	87 hrs. (35 Category I)
N-R	7/1/98-1/1/2000	75 hrs. (30 Category I)
S	7/1/98-10/1/1999	62 hrs. (25 Category I)
T-Z	7/1/98-7/1/1999	50 hrs. (20 Category I)

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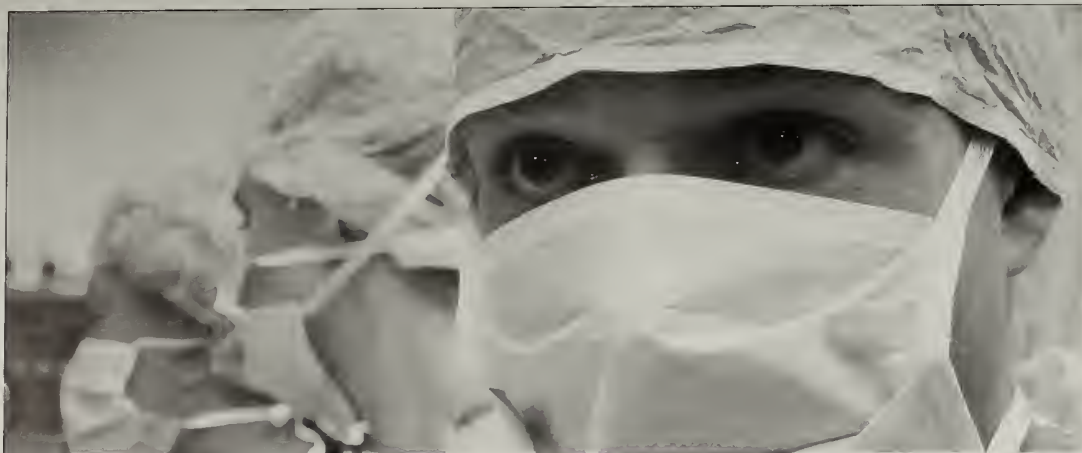
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Utlak...

continued from page 1

member of the Ohio delegation to the AMA.

He has been active, as well, on the local level of organized medicine, serving as president of the Canton Academy of Medicine and the Stark County Medical Society (SCMS). He currently serves as a member of the board of trustees for the SCMS.

Dr. Utlak also served as a member of the founding Board of Trustees for the Ohio Chapter of the American College of Cardiology (ACC), and as chair of the ACC/Ohio Chapter's Private Sector Committee. He is presently a member of the ACC's Section Council on cardiovascular disease which represents the ACC to the AMA.

An active political advocate for medicine, Dr. Utlak has served as chair of the medical division of the Finance Committee of the Stark County Republican Party, and has given numerous speeches on politics and medicine to local service organizations. He is also a member of the OSM's Physician Legislative Action Network (PLAN) and the Ohio Medical Political Action Committee (OMPAC).

Dr. Utlak, his wife, Barbara, and son, David, live in Canton. ■

Next month, Ohio Medicine will feature an interview with the candidate that presents his hopes and goals for the OSM if he is chosen the association's next President-Elect.

Bills, Laws & Rules

HMOs respond to accountability issue



The Ohio Association of Health Plans says if managed-care accountability bills pass, there will be more, not less, institutional control over physicians. The OSM wants to know what you think.

The Ohio Association of Health Plans (OAHP) has responded to the OSM and lawmakers' attempt to put managed-care accountability at the top of this year's legislative agenda.

The title of the OAHP four-page report, "Legislative proposals will result in unnecessary litigation, costly premium increases, loss of insurance and no improvement in quality of care," sums up the association's dislike for House Bills 641, 677, 685 and Senate Bill 206, all of which make managed-care plans liable for the medical decisions they make and accountable to their enrollees in other ways.

According to the OAHP report, the bills are "based on a faulty premise: that health plans rampantly deny needed services to enrollees." The report

states that a recent study of physicians proves that health plans deny coverage of recommended services in only 3% of cases.

Other points in the report include:

- Distinction between role of the provider and payor.

"HICs (health insuring corporations) make decisions about coverage, that is about when a particular service or category of services falls within the scope of the benefits financed by its premiums and agreed to by contract. Providers render clinical health care to patients consistent with their independent professional judgment. Health plans do not practice medicine."

- Defensive utilization review.

"In much the same way physicians have been forced to practice defensive medicine to avoid malpractice litigation, health plans will be forced to practice defensive utilization review, providing coverage for medically unnecessary, unbeneficial care."

- More institutional control over physicians.

"A possible consequence of expanding medical liability to health plans

may be an increase in health plan oversight of physicians and their actions to limit expanded liability risks. Provider-sponsored HICs would also experience magnified liability."

"We'd like to hear what our members have to say about these comments," says Tim Maglione, director of OSM's Department of Legislation.

The OSM will prepare a response to all of the points in the report, says Maglione, shaped, in part, by members' comments.

The OSM has stated its support for managed-care accountability legislation and currently backs House Bill 677. ■

Take Action

To comment on the OAHP report, please contact Tim Maglione, 1-(800) 766-6762, Ext. 220, e-mail: legis@osmo.org

Pages

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Slow-paying Medicaid HMOs have been a source of complaints lately, at the OSM. Now the association wants to know just how widespread the problem is.

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OSMA's Annual Meeting is just one month away. It will pack your weekend full of activities. You are invited to attend, May 15-17 in Cleveland.



13

Tobacco control may be up to the patient, but there are a number of things physicians can do to help. The OSM's Public Health Committee offers some suggestions.



16

Compliance plans may be your best defense against charges of fraud and abuse, but do you know how to develop one? Organized medicine can help.

Medical Board Report

Board to notify when licenses lapse

Currently, if you hold a medical license in Ohio, you receive a notice from the State Medical Board when it's time to renew your license. If you do not respond to the renewal request, your license lapses without any further comment or notification from the board. Now, that's about to change.

The board's Legislative Liaison Committee discussed recently how the board might reduce the number of instances when a physician inadvertently allows his or her license to lapse because they have not responded to renewal requests. In those cases, physicians—knowingly or unknowingly—are engaged in the unlicensed practice of medicine.

That fact concerned the Ohio Osteopathic Association enough to ask the board whether or not it would pursue criminal charges against doctors who may have placed themselves in this situation.

In reality, the problem is not all that common. According to board figures, approximately 2,000 licenses fail to renew each renewal period, and, of that total, about 250 later ask for reinstatement of their licenses.

The board is concerned that these physicians will probably continue to practice medicine, but it typically does not pursue prosecution of physicians whose licenses have lapsed inadvertently.

Nevertheless, the committee suggested that the board begin to send one-time notices to doctors who have had licenses but who have not yet renewed them. The notice would alert the doctor that his or her license will expire on a certain date. It would further alert them that continued practice will constitute a violation of the medical practices act. The board voted to proceed with such notifications with some board members expressing surprise that this is not already being done.

Of note:

Pain rules still in works...The board continues to solicit comments on its intractable pain rules, including comments from the OSMA, in order to gain more consensus. There is a perception from some doctors that the rules, as presently drafted, are so detailed and structured that technical violations will be almost unavoidable. The board is reluctant to

create a climate where doctors are afraid to prescribe, but it sees itself as an agency that must protect the public and put forth regulations that do so. The board hopes that its rules will set standards, and guide physicians on better pain management. But, in view of some of the criticism it has already received, it has agreed to slow down the process and solicit more input before finalizing the rules.

Activities during license suspensions...The board's Scope of Practice committee has approved a document entitled "Permissible Activities During License Suspension."

Questions about Meridia...Members of the board's Prescribing Committee have asked Knoll Pharmaceuticals for further information about its new drug, Meridia, an anorexic, with regard to valvular disorders. The company will provide the committee with more ongoing study reports about possible risks involved with use of the drug. ■

Ohio ranks tough on discipline

How many physicians were disciplined by the State Medical Board of Ohio last year? What actions did the board take against licensees?

Each year, Public Citizen, a consumer advocacy group, publishes an annual report that ranks each state medical board according to its disciplinary actions. The group's 1997 report is due this month.

In 1996, Ohio ranked first among states with more than 25,000 physicians in punishing doctors and other providers. The board revoked or restricted licenses at a rate of 4.75 per 1,000 physicians, says a report in the *Columbus Dispatch*.

Last year, 134 disciplinary actions were filed against Ohio licensees, which in addition to doctors, include physician assistants, podiatrists, massage therapists and others. In each action, the board has taken a tougher stand, a trend that appears to be nationwide.

Still, this is a small number of the 34,000 licensed physicians in the state, and a small portion of the 3,000 complaints the board received in 1997. About 1,800 of those complaints were followed by in-depth investigations.

The greatest number of license revocations and indefinite suspensions were imposed on doctors who are addicted to drugs or alcohol or who are trafficking in drugs. The board takes an especially hard stand on impaired physicians with multiple relapses, the article states. ■

Dr. Somani selected to board

Peter Somani, MD, Columbus, the former director of the Ohio Department of Health, has been appointed to the State Medical Board of Ohio by Gov. George V. Voinovich. Dr. Somani replaces Thomas Greter, MD, Pepper Pike, whose term expired. Dr. Somani's term will run through March 18, 2003. ■

Bill requires release of DUI test results

A new bill introduced in the House by Rep. Jack Ford (D-Toledo) raises the bar on the type of help health-care providers must now give police officers who suspect someone involved in a traffic accident was driving under the influence of alcohol or other substance at the time.

House Bill 707 requires physicians and other providers to supply the results of a test of a person's blood, breath or urine to police officers if the results indicate the person may have prohibited alcohol or drug concentration, and that person drove a vehicle that was in an accident within the two hours preceding the test or if the physician knows, or has reasonable cause to believe, the person operated a vehicle within that two-hour period.

Ohio Medicine reviewed the laws governing the withdrawal of blood of DUI suspects (who are unconscious) in its January 1998 issue ("Court order not necessary for DUI's blood sample.")

That article noted that Ohio Revised Code 4511.191 provides that all persons who operate motor vehicles on Ohio's public highways give their implied consent to submit to tests to determine the content of alcohol or drugs in their blood.

"It's not battery or an illegal act for a physician to withdraw blood from a drunk driving suspect when requested to

do so by a police officer," the article states.

The issue raised is confidentiality. Once tests have been done by physicians in private practice or in hospital settings and not at the request of police, to what extent are physicians bound by patient confidentiality? If passed, the bill would clarify the matter. ■



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How the OSMA can help you

The OSMA has received complaints about several Medicaid HMOs that are slow to pay claims and Cleveland's MetroHealth System sent a letter to the Ohio Department of Insurance last year expressing concern with an emerging pattern of nonpayment by Medicaid HMOs.

OSMA members, of course, may use the ombudsman staff to help collect their unpaid claims, says Bill Fry, director of OSMA Ombudsman Services, and can help resolve your claim with a Medicaid HMO that may be slow to reimburse you for your services. Contact the OSMA Ombudsman Services at, 1-(800) 766-6762, e-mail: ombud@osma.org. Also let the staff know if you are experiencing any difficulties with Medicaid HMOs that have been slow to pay your claims. ■

Indepth Report

HMOs slow to reimburse?

The OSMA has received several requests for help from members who have had difficulty collecting payments from Medicaid HMOs.

One pediatric surgeon in Cleveland writes he is increasingly frustrated by "significant problems" encountered with the HMO Total Health Care.

"Our issues range from authorization and precertification to claims adjudication and we are receiving little cooperation from THC," he says. "Our most significant problems are with claims adjudication and the problems have grown progressively worse the past two years."

He's not the only provider experiencing slow pay from Medicaid HMOs. The OSMA has received other complaints, and according to reports in Cleveland's *Plain Dealer*, MetroHealth

System sent a letter to the Ohio Department of Insurance at the end of last year urging the department to practice more vigilant oversight of health plans serving the poor.

Is problem widespread?

Richard Tuck, MD, Zanesville, one of the OSMA members who sits on the Ohio Department of Human Services' Medical Advisory Committee, says he has learned recently of difficulties physicians are having with HMOs that are slow to pay but he is unaware, yet of how widespread the problem is.

"I've heard it may be a problem in Cuyahoga and Hamilton counties," he says, "but if this problem is growing, we'd like to know about it."

So would the OSMA.

OSMA members, of course, may use the ombudsman staff to help collect their unpaid claims, says Bill Fry, director of OSMA Ombudsman Services.

How OSMA helps

"We'll contact the carrier to have the claim resolved," he says. "We also work with the Ohio Association of Health Plans (OAHP) to resolve disputes between HMOs and physicians."

Although Fry says his office has received complaints about slow-paying HMOs from members, he also is uncertain how far-reaching the problem may be and wants to hear from others.

"If we know this has become a widespread problem, we can gather the information and make the Ohio Department of Insurance (ODI) and the OAHP aware of it. HMOs have a responsibility to pay claims in a timely manner. If this isn't being done, we need to know."

Some of the problem, says Fry, may come from the system itself.

"It's similar to working with the BWC's (Bureau of Workers' Compensation) Health Partnership Program," says Fry. "Doctors aren't paid directly by the state anymore, and that may create some

of the problems."

Kip May, deputy director of ODI, says he's aware of several HMOs in the northeast section of the state that had "bad claims administering systems."

"That was about six or 12 months ago. In those cases, there were some legitimate concerns about claims that were taking 90 to 120 days to pay."

Contracts prevail

May also attributes some of the complaints about the timeliness of claims payment to misunderstandings and miscommunication.

"We hear complaints from providers who cite the prompt pay law but they don't realize that the statute states if you enter into a direct contract with a payor, the terms of that contract prevail over the prompt-pay law."

In other words, if your contract with a carrier says you will be paid in 45 days, your payment won't be considered late, even though the prompt-pay law states you must be paid in 30 days.

May says he isn't aware of any particular problem with slow-paying Medicaid HMOs. "We've had no more complaints about Medicaid HMOs than we have about other payors," he says.

Still, what concerns Dr. Tuck and others is what happens to patients in situations where HMOs haven't paid provider claims for a lengthy period.

"I assume that the doctors continue to take care of the patients, but I am aware that some practices are beginning to question whether or not they can continue to accept Medicaid patients. That could become a real problem for the Medicaid population if more physicians decide they can no longer afford to treat them," he says.

The OAHP was contacted for a response, but would not make any general comments on the problem, saying they would work with the OSMA on individual complaints. ■

From HOME REMEDIES To HMOs



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Dateline Ohio

State shrinks number of Medicaid HMOs

Doctors are advised to review their contracts with the Medicaid plans in their county and brush up on termination provisions.

If you have patients enrolled in Medicaid HMOs, now might be a good time to pull out your contracts with the plans in your county and brush up on termination provisions.

Beginning in June, the Ohio Department of Human Services (ODHS) will start to phase out Medicaid HMOs in each county.

"It's conceivable that once the state cancels its Medicaid contract with an HMO, the HMO will terminate its contracts with providers," says Nancy Gillette, JD, OSMA Division of Legal Affairs. "In such cases it's prudent to know what your arrangements are with an HMO if the HMO chooses to terminate your contract."

Phase-out planned from onset

The ODHS had originally awarded contracts to an unlimited number of HMOs in each of the seven counties where managed care is mandated and in each of the nine counties where managed care is voluntary. But the department has always planned to limit the numbers, says John Allen, spokesperson for the ODHS.

"This isn't an idea we've suddenly sprung on anyone," he says. "It was planned from the beginning that the marketplace would select which HMOs stay in business."

Market share will be the sole factor in deciding which Medicaid HMOs stay. HMOs that have at least 15% of the market share in Butler, Franklin, Hamilton, Lucas, Montgomery and Summit

counties will continue to do Medicaid business. If only two HMOs have more than 15% of the market share, then the HMO with the next higher share also would continue.

"There will be a minimum of three HMOs in each county," says Allen, "but there could be more. In Cuyahoga, HMOs with at least 10% of the market share will continue. If only three have more than 10% of the market, then the HMO with the next highest share also would continue. In Cuyahoga, then, there will be a minimum of four, but, again, there could be more."

Market shaping itself

Allen says the marketplace is already showing signs of shaking itself out. HMOs with larger market shares are beginning to buy enrollees from HMOs with smaller enrollments. Alternatively, some HMOs are forfeiting enrollees in counties where they lack strength and are putting their efforts in gaining market share in counties where they are more competitive. The department has already placed enrollment freezes on several HMOs that wish to sell their subscribers.

HMOs that don't make the department's short list can continue to serve their members through September 1998. After September, enrollees who haven't been bought by one of the three or more remaining HMOs will be able to select the HMO they wish to join. Otherwise, they will be placed in fee-for-service arrangements until they reach a decision.

Letters will go out to Medicaid recipients in June, informing them which HMOs have been selected for that county. Since contracts will be awarded to the three with the largest enrollments, Allen says the effect on Medicaid en-

rollees is likely to be minimal. "Only a minority will need to change," he says.

Criteria not counted

The department did not consider performance, or even the number of enrollee/provider complaints in making its selection. "The marketplace has taken care of that," says Allen, noting that Medicaid enrollees gravitate to plans where they are satisfied with the care they receive.

Fiscal stability is also not a factor in the department's selection of Medicaid HMOs, and that's a matter that raises some OSMA concern since there are a few Medicaid HMOs that have been traditionally slow to pay providers. (See related story on page 6.)

"That's why physicians should know what their responsibilities are, and also what the HMO's responsibilities are in case a plan terminates your contract," says Gillette. "Among other things, you'll learn what you need to do to collect your claims." ■

Take Action

The OSMA offers a contract review service through its Division of Legal Affairs which points out concerns with plan contracts, including any that may be associated with termination provisions. To take advantage of this service, or for more information about it, contact Kate Hunter, OSMA Division of Legal Affairs, 1-(800) 766-6762, Ext. 129.

Which HMOs will stay?

The Department of Human Services' criteria for remaining a Medicaid HMO is at least 15% of the marketshare (10% in Cuyahoga county). The HMOs likely to stay (*), and those likely to fold:

Butler County

- *Butler Health Plan (55%)
- *DayMed (19%)
- HMO Health Ohio (8%)
- Health Power (5%) – frozen

Cuyahoga County

- *Personal Physician Care (27%)
- *SuperMed (19%)
- *QualChoice (18%)
- *Total Health Care Plan (17%)
- Emerald (4%)
- Cuyahoga Health Plan (3%) – frozen
- Health Power (2%) – frozen
- Genesis (1%) – frozen
- DayMed (1%)

Franklin County

- *Columbus Health Plan (52%)
- *Health Power (19%)
- Total Health Care Plan (6%)
- Personal Physician Care (5%) – frozen
- HMO Health Ohio (5%)

Hamilton County

- *Paramount (42%)
- *HMO Health Ohio (26%)
- *Cincinnati Health Plan (21%)
- DayMed (1%)

Lucas County

- *Paramount (42%)
- *Family Health Plan (29%)
- *HMO Health Ohio (15%)
- Personal Physician Care (3%) – frozen

Montgomery County

- *Dayton Area Health Plan (50%)
- *DayMed (25%)
- Health Power (13%)
- HMO Health Ohio (3%) – frozen

Summit County

- *SummaCare (28%)
- *SuperMed (27%)
- *Personal Physician Care (22%) – frozen
- Total Health Care Plan (6%)
- Emerald (3%)
- Genesis (2%) – frozen
- MedPlan (2%) – frozen

In October, counties with voluntary enrollment will become mandatory counties, except for Marion where only 5% of eligible Medicaid recipients have enrolled.

The term-limit effect: Legislators leave now

Term limits won't become effective until the year 2000, but lawmakers are already leaving office. Here's a look at who has left recently (for an updated list, check out the OSMA Web site, www.osma.org). Is your representative or senator on the list? If so, now is the time to become acquainted with his or her replacement and to educate them on the OSMA and medicine's views on pending health-care bills.

Representatives:

C.J. Prentiss (D-Cleveland)
8th District
Running for a state senate seat

Vermel M. Whalen (D-Cleveland)
12th District (Retiring)

Michael Wise (R-Mayfield Village)
15th District
Running for Cuyahoga County auditor

Edward Kasputis (R-Olmsted Twp.)
16th District, (Retiring)

Dan Brady (D-Cleveland)
17th District
Running for a state senate seat

Charleta Tavares (D-Columbus)
22nd District
Running for Ohio Secretary of State

James Mason (R-Columbus)
25th District
Running for the 10th District Court of Appeals, Franklin County



Charleta Tavares



James Mason

Mark Mallory (D-Cincinnati)
31st District
Running for a state senate seat

William Batchelder (R-Medina)
81st District
Running for Medina County Common Pleas Court judge

Richard Hodges (R-Wauseon)
82nd District (Retiring)

Lynn Wachtmann (R-Napoleon)
83rd District
Running for a state senate seat

Senators:

M. Ben Gaeth (R-Defiance)
1st District
(Retiring)

Alan Zaleski (D-Vermillion)
13th District
(Retiring)

Jeff Johnson (D-Cleveland)
21st District
Running for 11th District congressional seat

Patrick Sweeney (D-Cleveland)
23rd District
Running for Cuyahoga County commissioner's seat

Judy Sheerer (D-Shaker Heights)
25th District
(Retiring)



Wm. Batchelder



Alan Zaleski



Judy Sheerer

AG files suit against physicians

Ohio Attorney General Betty Montgomery has filed a lawsuit against five physicians, all members of the Smith Clinic in Marion.

The suit claims the five enriched themselves by working to ensure that OhioHealth's Marion General Hospital bought MedCenter Hospital. Once the sale was completed, the doctors would join Marion General to convert MedCenter into a for-profit outpatient center. The doctors would then be partners in MedCenter's business.

Since the five doctors all held positions on OhioHealth's board of trustees, however, and were able to influence the decision of a sale, the suit charges them with conflict of interest.

The sale of MedCenter to Marion General has been approved by Montgomery's office, but the suit is intended to stop the doctors from buying MedCenter's assets.

The suit asks the doctors to pay the Ohio MedCenter Foundation \$6.1 million in damages.

"If all the facts in this case are proven," says Nancy Gillette, JD, OSMA legal counsel, "it could have an impact on physician-hospital arrangements, but only in a very limited sense. If the attorney general wins the suit and you are in a small town where all referrals are made to one hospital by a majority of the town's physicians, there might be some concern about the arrangement."

Most physicians, however, can relax, she says.

"The attorney general's office told us it doesn't intend to look into all physician-hospital arrangements around the state," says Gillette. "This was a special case." ■

Medicaid now covers smoking cessation aids

You can now prescribe Nicotine Replacement Therapy for your Medicaid patients.

Beginning April 1, certain nicotine replacement products, such as Smith-Kline Beecham's Nicorette (2 and 4 mg), Nicoderm CQ (7,14, and 21 mg), and McNeil's Nicotrol (15 mg), are fully covered without prior authorization and without copay. This is the first time the Ohio Department of Human Services has ever fully covered smoking cessation products.

To qualify for the coverage, a Medicaid patient must receive a written prescription for the product, although these are over-the-counter medications. He or she is also encouraged to enroll in a behavioral support program, like "Com-

mitted Quitters," a 10-12 week personalized smoking cessation program, offered free by the makers of Nicorette and Nicoderm CQ. Enrollment is not mandatory for coverage, however.

The pharmacist will process the prescription like any Medicaid prescribed product or service.

Ohio's coverage of these products is consistent with the Agency for Healthcare Policy and Research's smoking cessation guidelines, published in collaboration with the Centers for Disease Control, and released last April.

Current statistics show that Ohio ranks third in the nation in smoking prevalence, with 28.5% of the population smoking. ■

Take Action

If you would like to become acquainted with your legislator contact, Krista Bislaine, OSMA Department of Legislation, 1-(800) 766-6762, Ext. 223.

Privatization of UC hospital faces roadblock

A lawsuit challenging the privatization of a public teaching hospital in Cincinnati is scheduled for a hearing April 1 in the Hamilton County Common Pleas Court.

University hospital was privatized on Jan. 1, 1997. A taxpayers group, however, quickly filed suit saying the reorganization of the hospital violated a "separation of powers" clause in the Ohio Constitution.

The group, as well as other opponents, object to the deal because it amounts to the transfer of public property without fair compensation, and could reduce access to health care for the city's indigent population. Supporters say that privatization was necessary for the hospital's long-term survival.

Meanwhile, four separate labor unions, including the University of Cincinnati House Staff Association which represents medical residents, filed an unfair labor practice charge with the State Employment Relations Board (SERB), stating that the hospital divested public employees of all their rights, including the right to collective bargaining, when it privatized.

SERB rejected the claim, however the Ohio Supreme Court recently ordered SERB to file a complaint and conduct a hearing on the matter.

In its decision, the court said SERB abused its discretion in dismissing the charge when "there is probable cause to believe that an unfair labor practice occurred."

Dissenting justices noted that: "The majority opinion, in essence, holds that any decision by a public employer to privatize is an unfair labor practice, and that SERB has the statutory authority to decide whether or not to file complaints."

Ohio Medicine will continue to provide updates on this story. ■

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April

Date: April 22
Time: 8-9 a.m.
Hours: 1.0
Title: Lung Cancer
Where: Robinson Memorial Hospital, Ravenno
Sponsor: Robinson Memorial Hospital
Contact: Pat Dios, (330) 297-2540

Date: April 22
Time: 7:30 a.m.-12:30 p.m.
Hours: 4.0
Cost: \$50/\$35
Title: Cardiology Update 1998
Sponsor: Lake Hospital System
Where: Lake Hospital System, Willoughby
Contact: Janice Krehel, (216) 953-6216

Date: April 25
Time: 7 a.m.-5 p.m.
Hours: 7.0
Cost: \$150
Title: Day of Medicine Review VIII for Primary Care Physicians
Sponsor: Doctors Hospital
Where: Doctors Hospital, Founders Auditorium, Columbus
Contact: Dr. Robert E. Patts, (614) 297-4245

May

Date: May 2
Time: 8:30 a.m.-5:30 p.m.
Hours: up to 7
Cost: \$95
Title: Second Annual Mexican-American Binational Course in Respiratory Disease: Respiratory Infections
Sponsor: University Hospitals, Cleveland
Where: Farum Conference Center, Cleveland
Contact: CME registrar, (216) 844-5050

Date: May 6
Time: 8-9 a.m.
Hours: 1.0
Title: Female Urinary Incontinence
Sponsor: Robinson Memorial Hospital
Where: Robinson Memorial Hospital, Ravenno
Contact: Pat Dios, (330) 297-2540

Forum

CPT codes no longer work

To the Editor:

It's time for physicians to take a deep breath and focus on the CPT system. The emperor has no clothes! The current system has terrible deficiencies which physicians are ignoring.

Who would design a system with Evaluation and Management codes that are so complex as to defy any consistency in coding? I have been to several coding seminars and after hours of tedious explanations, it's still impossible to take individual patients with multiple problems of varying complexity and code them in a reproducible way.

Even if you buy a \$500,000 computer system which forces you to fill in the proper blanks to cover history and physical examination bullet points, an audit can determine that many of these entries are not relevant to the diagnosis. You may be expected to pay back "overcharges," be fined \$10,000 per error, and even end up in jail for fraud.

Equally frustrating is the system for evaluating new procedure codes. For example, there are many laser treatment procedures that are FDA-approved and rigorously tested. Yet, by not awarding CPT codes for these procedures, insurers believe they are saving money. In actuality, many physicians perform these treatments and code them in a variety of ways, based on the physician's best guess as to their relative value. The physician is at risk for an audit which could disallow charges for the previous several years. No systems are in place to prospectively review these novel but necessary coding methods.

What can we do? First, recognize that the emperor has no clothes. The system we, as physicians, have worked so hard to perfect is a failure. The E&M section of the CPT code system must be scrapped.

In its place, we need a system of paying for cognitive work, based solely on the diagnosis of the patient. New codes

must be authorized for procedures with medical merit. The amount of payment for these new technologies is a separate issue entirely. This is something physicians can understand and implement quickly. Insurance companies and Medicare should be welcome to review our records since they pay the bills, however this review should be judged on medical merit, not coding requirements.

Good faith efforts by physicians should not be met with threats of audit that none of us can withstand because of the design of the system. It's impossible to have a system which is fair in every circumstance, but at least let's not have an impossible system. Alternatively, we will all come to embrace capitated care as the only method which allows us to escape the current CPT system. If this occurs, our patients will suffer.

Robert T. Brodell, MD
Warren

New E&M guidelines are last straw

Editor's note: The following letter was sent to *U.S. Congressional Representative James Traficant, Jr.* The author asked that it be published also in *Ohio Medicine*.

To the Editor:

With the implementation of the new Medicare E/M guidelines in January 1998, an unprecedented sense of despair has seized not only myself, but virtually all doctors. The level of documentation required by these new guidelines is not only unreasonable, it's virtually impossible to comply with.

These new Medicare codes are the last straw. There is no way that my colleagues or I can comply with the changes as they are presently written.

We are being forced to make a painful decision to either practice good medicine or good prose. There isn't enough time in the day to practice both. Do you want your physician to be a physician or a recordkeeper?

The new codes have nothing to do with the standard of care or the decision-making process. If the codes aren't modified, many honest physicians, not only in Youngstown but nationally, will be punished unjustly and portrayed as dishonest to their patients by a beefed-up fraud and abuse task force. I'm so frustrated by this potential of being portrayed as a cheat that I would seriously consider not treating any more Medicare patients.

Let doctors write the notes that they write and practice the medicine they

were trained to practice and remove the yoke of bureaucratic regulations from their backs.

The hours are drawing short as the date for full compliance approaches (July 1, 1998.) After that, the fraud-busters will be at our doors pulling charts and crying foul. Many excellent doctors who are just poor recordkeepers will be destroyed.

Enough is enough.

Joseph Ambrose, DO
Youngstown

The OSMa has received many similar complaints in response to its request for comments on the E&M Documentation Guidelines. See related story on page 1.

PRS aims for "ripple effect"

To the Editor:

In response to the articles "Anthem claims coronary network improves cardiac care for all" and "Data sharing helps define best practices" in January's *Ohio Medicine*, Peer Review Systems, Inc. (PRS) commends Anthem Blue Cross and Blue Shield for its forward vision and commitment to quality measurement.

The articles also provide an opportunity to augment and support Anthem's notion of a quality improvement "ripple effect," especially in cardiac care. As the peer review organization in Ohio, PRS coordinates statewide activities associated with the Cooperative Cardiovascular Project (CCP), HCFA's first national quality improvement initiative for Medicare.

More than 120 Ohio hospitals that treat heart attack victims actively participated in CCP by receiving baseline performance feedback from PRS physicians and nurses from late 1996 through 1997. Of those, 109 hospitals continued with the development and implementation of quality improvement plans.

Remeasurement results to date indicate that these hospitals collectively are raising the bar on the quality of heart attack care.

PRS offers similar quality improvement projects. Participation is free and completely confidential. Through projects like these, any health-care provider, can create a quality improvement "ripple effect."

Donald G. Norris, MD
Corporate Medical Director
Peer Review Systems, Inc.
Westerville

OSMA News



1998 Annual Meeting

OSMA delegates head to Cleveland

The 1998 OSMA Annual Meeting will take place May 15-17 at the Renaissance Cleveland Hotel.

OSMA delegates and alternates will meet in Cleveland to consider resolutions and set policy for the association for the coming year.

The format for the event has been streamlined this year. The First Session of the House of Delegates will begin on Saturday morning with the Final Session on Sunday morning.

OSMA's Organized Medical Staff Section will hold its Annual Meeting on Friday, May 15 from 1 to 5 p.m. (see related story below), and the OSMA Alliance Annual Meeting will take place at the Sheraton City Centre Hotel in Cleveland May 14-15 (see related story at right).

The schedule of activities include:

- **Presidential Installation**
The installation of Lance A. Tal-

mage, MD, Toledo, as OSMA president will take place during the First Session of the House of Delegates on Saturday morning. A reception honoring Dr. Talmage will be held that evening.

- **Resolutions Hearings**

Resolutions committee hearings will be held from 1:30 to 4:30 p.m. on Saturday. Resolutions Committee 1 will be devoted to the Task Force 2000 report and hearings will begin at 2:30 p.m.

- **Final Session**

The Annual Meeting will conclude with the Final Session of the House of Delegates on Sunday morning.

The Opening Session will start at



Cleveland will be home for OSMA Delegates and Alternates May 15-17 when they meet for the OSMA's Annual Meeting at the Renaissance Cleveland Hotel

10 a.m. Saturday. District caucuses will meet Sunday morning prior to the Final Session.

OSMA's Department of Continuing Medical Education will offer an educational forum on outcome measurements Saturday morning before the House.

Visit the OSMA Web site (www.osma.org) for more information. ■

Nancy Goorey new OSMA-A president

The OSMA Alliance will install Nancy Goorey, DDS, as president at the Alliance's Annual



Nancy Goorey

Meeting, to be held May 14-15 at the Sheraton City Centre Hotel in Cleveland. The meeting precedes the OSMA Annual Meeting which will be held May 15-17 at the Renaissance Cleveland Hotel.

The OSMA-A House of Delegates will hold its Opening Session Thursday, May 14 from 5 to 7 p.m. The second session begins Friday morning, May 15 at 8:30 a.m. Caramine Holcomb, AMA-A field director, will serve as the keynote speaker. The third session will be held at 1:30 p.m., following the awards luncheon, and the meeting will end with a 4:30 p.m. reception honoring newly-installed president Dr. Goorey.

Alliance projects, newsletters, directories and pictures from counties throughout Ohio will be displayed throughout the event. ■

Take Action

For more information about the OSMA-A Annual Meeting, contact Deborah Blackwell in the OSMA Alliance office, 1-(800) 766-6762, Ext. 403, e-mail: alliance@osma.org. Also check the OSMA Web site, www.osma.org, for more information about Alliance activities.

OMSS members focus on unions, networks at their Annual Meeting

Should members of an organized medical staff form a union? Should physicians form their own networks?

Those issues will be addressed Friday, May 14 when members of the Organized Medical Staff Section (OMSS) hold their annual business and educational meeting at the Renaissance Cleveland Hotel. The meeting will be held from 1-5 p.m. and precedes the OSMA Annual Meeting which will take place at the same location May 15-17.

Although details were not available at press time, Shar Wackman, OSMA

membership staff specialist, says the section on physician unions will feature a physician representative from organized labor who will speak on the benefits of joining unions. A member of the OSMA legal staff will outline state and federal labor laws as well as federal antitrust laws and their impact on physician unions.

Among those speaking on the evolution of physician networks is Ron Fasano of the Eastern Ohio Physicians' Organization and Tom Wolff of Michigan Medical Advantage, who will speak

about his work with IPAs and single-specialty networks.

The OSMA-OMSS is comprised of members of hospital and other organized medical staffs throughout Ohio. ■

Take Action

For more information about the OMSS Annual Meeting, or about the OMSS itself, contact Shar Wackman, 1-(800) 766-6762, Ext. 109, or e-mail her: members@asma.org

Public health

Tobacco Control: Things you can do

Ohio's problem of youth access to "the most addictive drug in the world" could improve with national regulation over the tobacco industry, but today Ohio has much to accomplish on its own. Recent statistics from the CDC show that Ohio has the third highest percentage of smokers in the nation at 28.5% and the highest percentage of male smokers at 33.9%. Even worse news is that 39% of our children are smokers. An estimated \$2.16 million in illegal sales of tobacco products are made to Ohio children each year.

What can physicians do?

1. A physician who speaks out by writing a letter to the editor, and calls or writes his/her legislator about local, state or national social/political issues, has impact that engenders immeasurable respect and consideration.

2. City councils and health commissions should be encouraged to license tobacco vendors. Currently, only two Ohio communities do.

3. Local prosecutors should be en-

couraged to take action against vendors who illegally sell tobacco to minors.

4. Legislators should be encouraged to make illegal tobacco sales a civil offense rather than a criminal misdemeanor.

5. Health departments should contact the Ohio Department of Health on how to do compliance checks of vendors. The number at ODH is (614) 466-2144.

6. Tobacco Free Ohio (TFO) as well as the OSMA, has information and position statements on all legislation regarding tobacco. For more information on TFO call Michelle Chippas at 1-(800) 686-4357. For the OSMA's position on tobacco-related legislation call Maria Eshelman Bump, Department of Legislation, 1-(800) 766-6762, Ext. 222.

7. Discuss nicotine dependency with patients, display literature on smoking cessation in your medical office, and personalize the message when possible. For the latest information on smoking cessation, the Nicotine Dependence Center at the Mayo Clinic holds annual

physician and staffing training programs and has a year-round, one-week residential treatment program for the seriously dependent patient. Call 1-(800) 344-5984 for more information.

8. Micro-Mass in Raleigh, N.C. and Medifor Inc. of Townsend, Wash. both have computer-based patient education systems. Additionally, a program in conjunction with Smith-Kline Beecham called Committed Quitters is free to those using Nicoderm and Nicorette.

9. To obtain information on smoking cessation practice guidelines call or write the U.S. Department of Health and Human Services, Agency for Health Care Policy and Research at 1-(800) 358-9295, Publications Clearinghouse, P.O. Box 8547, Silver Springs, MD 20907, or visit their Web site at: www.ahcpr.gov - Theda Jessen, OSMA Alliance Health Promotion Chair, OSMA Public Health Committee

Turn off your TV

April 22-28 is designated as "Turn Off the TV" week by the AMA, the AMA Alliance and several other organizations. This effort is to encourage people to choose entertainment and activities other than TV. The OSMA-A supports this activity and asks you to consider taking this challenge.

National "Turn Off the TV" week is part of a growing effort to reduce the excessive amount of television that Americans watch. The annual event moves beyond the old discussions about program content and instead focuses on what TV viewing displaces: creativity, productivity, healthy physical activity, civic engagement, reading, thinking and doing.

For more information, call (202) 887-0436, TV Free America, to join and receive brochures to distribute in your community. ■

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President's Perspectives

IMGs are physicians first

Last May, with just a little fanfare, I was proud to have the honor of being sworn in as the first international medical graduate president of the OSMA. I believe my election, in a small way, served as further proof that IMGs have become part of the fabric of American medicine.

It was in the late 1940s that international medical graduates first began immigrating to the United



Su-Pa Kang, MD

States. Later, in the 1960s the number of immigrations increased as the demand for interns and residents by U.S. hospitals increased. After their training, many IMGs

found themselves settling in underserved areas, both urban and rural, where American medical graduates were hard to come by. In fact, now even though IMGs are an integral part of all aspects of medicine, you will find that many of the underserved areas of the country are still served to a large degree by IMGs.

Today, we consider ourselves part of mainstream medicine, with the same concerns and challenges as American medical graduates. We worry about the impact of managed care on our patients. We are concerned about the never-ending campaign by allied practitioners to expand their scopes of practice. And we are proud when the OSMA is successful in passing much-needed managed-care reform legislation or tort-reform legislation.

But as IMGs, we do have several issues that are of specific concern to us — medical licensure and immigration issues — to name just two. The

OSMA hosted an IMG meeting last month that allowed us the opportunity to focus on these issues and to discuss possible solutions.

I firmly believe that membership in organized medicine, while of great importance to all physicians, is of vital importance to international medical graduates. It provides us not only with the political means to address our specific concerns, it also provides us with a forum in which to work cooperatively with American medical graduates to achieve mutual goals. But IMGs should not stop at membership only. It is vitally important that we also assume leadership roles.

The American Medical Association formed its task force for international medical graduates in 1989. I was very happy to serve as one of the task force's first members. Last year, the AMA House of Delegates created a special section for IMGs. The OSMA's IMG Task Force was formed in 1991, and continues to work for IMG concerns today.

But more IMGs need to become involved in organized medicine. Only by working in concert with other IMGs, which now includes American-born physicians who went to medical school abroad, can we be successful in addressing the problems specific to our group. And only by working together with all physicians can we face the challenges ahead.

I think I speak for all IMGs when I say each of us is proud of our heritage and proud of our adopted country. And each of us remains committed to being the best physician he or she can be. We are truly being woven into the fabric of American medicine and all of us will benefit from that. ■

Proposed bylaws change

Introduced by: OSMA Council

Subject: Corporate Membership

WHEREAS, in 1985 at the request of the Physicians Insurance Company of Ohio (PICO) Council sponsored and the House of Delegates approved a resolution amending the OSMA Constitution and Bylaws to create a corporate membership category intended to allow PICO to insure physician groups under a then-existing insurance regulation; and

WHEREAS, subsequently, the insurance regulation was modified and Council has never approved any corporate membership programs or activities; and

WHEREAS, the existence of the corporate membership category may create misunderstandings about membership eligibility in the OSMA and its component societies; and

WHEREAS, the OSMA should evaluate and promulgate membership criteria and programs based on the current needs of physicians in the changing medical practice market; therefore be it

RESOLVED, that OSMA Constitution

and Bylaws be amended to delete the corporate membership category as follows:

Constitution, Article III, Section 1. Classes of members. This Association shall consist of the following classes of members:

— 9-Corporate Members —
Bylaws, Chapter 1, Section 2. Classification of Membership. —(f)— Corporate Members: Medical partnerships and corporations, one (1) or more of whose members or employees is an Active Member of this Association, are eligible for Corporate Membership in Ohio State Medical Association. Such Corporate Membership shall be at the discretion of the Council.

and, therefore be it further

RESOLVED, that the OSMA Group Practice Section and Committee on Membership Marketing conduct an investigation of the feasibility of future corporate and group membership programs, reporting back to the House of Delegates at its 1999 Annual Meeting.

Fiscal note: \$10,000

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OR

Practice Tips



What every office needs

Compliance plans are essential

Fraud enforcement activities have become more common, and physician practices are not immune. That's why compliance plans are now more important than ever.

The Office of the Inspector General (OIG) has developed a 1998 work plan from which will come major investigations into provider fraud and abuse practices – still a primary focus for the federal government. (For a look at some of the items on that plan, see related story at right.)

To protect yourself in any of these "hot target" situations, you should prepare a compliance plan for your office, says Jillian Phillips, a certified procedural coder in the OSMA's Department of Ombudsman Services.

"Compliance plans have become the next big thing," she says. "If you can produce a compliance plan for a reviewer and show that you have made a diligent effort in this regard, then chances are good you aren't going to be accused of fraud and abuse practices."

Good faith effort is key

Due diligence is an important factor in compliance plans, says Bruce Blehart, AMA's Office of the General Counsel, Health Law Division. "No compliance plan is better than a compliance plan you're not going to commit to."

Phillips agrees. "In order for the plan to have any effect, you need to show you are making a good faith effort to comply. Just having a compliance plan on file isn't good enough."

Compliance, of course, simply means that you document proof that you are abiding by the laws, regulations and guidelines that govern your practice.

"When a physician's office constructs a written compliance plan, it serves as a preventive measure of 'intent' – to guar-

antee that the office is providing and billing for services according to the laws, regulations and guidelines that regulate it," says Phillips.

"Having a compliance plan is just good practice," she continues. "Not only does it lay the groundwork for clean claims, but it also helps facilitate quality patient care."

Few resources

And the fact is, in today's environment, where fraud enforcement activities are a key government focus, such plans are becoming increasingly necessary. But because the area is still so new, there are few resources physicians can turn to when it comes to structuring a compliance plan for their offices.

Last September, the AMA published a "Federal Fraud Enforcement Physician Compliance" report that "provides the skeleton" for establishing a compliance program that can be incorporated into physician practices.

Physicians can also turn to an accounting firm or law firm in their area to help them construct a compliance plan that is designed for their particular practice, says Blehart.

Reportedly, the Medical Group Managers Association is also working on structuring a compliance plan that would work for group practices.

The OSMA's Phillips says that, although compliance plans need to be modified to fit the practice, they should contain at least the following four elements:

• Standards of conduct

Every plan should begin with a general statement of conduct that stresses the physician's commitment to the standards, policies and procedures with regard to all laws and regulations governing his or her practice.

• Education

Have in place effective compliance

training programs that are conducted at least annually. Some employees, such as the coding and billing staff, may need training more frequently. Fraud and abuse laws should be a part of this training.

• Auditing and monitoring

A regular review of the practice's claim development and submission process should be conducted, and billing clerks should look at claims and documentation on a regular basis to make sure they're qualified.

• Plan development and updating

The compliance plan needs to be written to reflect the types of rules, regulations and laws that affect the practice, and the plan needs to be updated on a regular basis.

"The existence of an effective compliance plan provides evidence that any mistakes were inadvertent," says the AMA's report, "and this evidence would be considered in determining whether a medical practice or other health-care entity has made reasonable efforts to avoid and detect misbehavior." ■

Take Action

If you have questions about compliance plans, contact the OSMA Department of Ombudsman Services, 1-(800) 766-6762. To order a copy of the AMA's report "Federal Fraud Enforcement Physician Compliance," contact the Ohio Medicine reader response line, 1-(800) 766-6762, Ext. 228 or ask for Item #8-98.

Are you on the OIG's target list

Provider fraud and abuse continue to be a major focus of the Office of the Inspector General (OIG). The OIG has developed a 1998 work plan from which will come major investigations into provider fraud and abuse practices. Below are a few of the items. The complete work plan is available on the OIG's Web site, www.dhhs.gov/progorg/oig

• PATH audits

Physicians at Teaching Hospitals (PATH) will need to be able to demonstrate compliance with Medicare rules that govern reimbursement for physician services provided in the teaching setting.

• Physician visit coding

In the past, the OIG has found that physicians are not accurately or uniformly using visit codes. This year, the OIG will enforce documentation guidelines for Evaluation and Management codes, and will also audit carriers to determine if they are adequately monitoring physician coding.

• Use of Modifier 25

This surgical modifier is used to claim "significant, separately identifiable evaluation and management services on the day of surgery." The OIG office will review whether or not physicians are using this modifier properly.

• Diagnosis codes

Do diagnosis codes on claims match the reason for ordering and providing various services? Medical reviewers will compare a sample of Medicare claims to beneficiary medical records to see whether or not there is a match.

• Billing service companies

Medicare claims will be reviewed to determine if those prepared and submitted by billing service companies are properly coded and in accordance with the physician services provided to beneficiaries. The reviewers will look for upcoding and/or unbundling procedure codes to maximize Medicare payments. ■

Tips for taming the E&M guidelines

Physicians as well as others in the medical community have been wrestling with the Evaluation and Management Documentation Guidelines since their inception in 1992.

The length and detail of the new proposed guidelines are overwhelming for the majority of physicians. The AMA is working with state medical and specialty societies to identify problems and improve the guidelines (see front page story), but the basic composition of the guidelines is here to stay, and the best thing physicians can do, says Jillian Phillips, a certified coding consultant in the OSMA's Department of Ombudsman Services, is to take some steps now so you're prepared when HCFA begins to enforce the guidelines this summer.

Here is what she advises:

- Pull charts that represent different situations within the office setting, such as: New patient encounters, established patient follow-up of ongoing problems; follow-up of resolving problems, etc.

- Perform a self-audit based on the new guidelines and determine the comfortable level of service for that particular situation.

"Most physicians have a certain amount of work they do routinely for each type of situation," says Phillips.

- Don't let the guidelines control you; take control of the guidelines!

"The Evaluation and Management codes are generated from medical necessity," says Phillips, "and most of the problem comes from physicians forgetting they have to: 1) treat the patient first; 2) document the encounter; then 3) select the proper level of service for it." ■

Take Action

If you have questions about E&M documentation, contact Jillian Phillips, certified coding consultant, OSMA Department of Ombudsman Services, 1-(800) 766-6762, Ext. 214. See page 1 for a list of coding resources the OSMA provides its members.

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My favorite Web site...

By W. Jeanne McKibben, MD

www.ama.org

"I find I use the AMA's Web site a great deal, especially the Physician Select feature, so I've bookmarked the site on my computer.



Dr. McKibben

"Physician Select has enabled me to refer my patients to other doctors, even in different parts of the country. You can locate a physician by specialty and by location (through the zip code). All physicians in the U.S. are listed in Physician Select, but AMA members can have their own Web pages which provide more specific information, for example, whether or not they are board-certified or have any special interests. It helped me find a doctor for one of my patients who was moving to Washington, D.C.

"I also like the ability to pull up information about AMA policy, and I go to the site as well for information on legislative issues.

"The only downside is that the site is not updated as frequently as it should be and corrections are made slowly."

What to look for: Sections on the site include: about the AMA, president's message, doctor and hospital finder, upcoming events, information for physicians and consumers, accreditation, ethics, and advocacy.

"Physician Select" lists 650,000 names of MDs and DOs. You can search for a physician by name, specialty or condition that particular physician treats. You'll find a map to the physician's office, office hours, and if he/she accepts Medicare and Medicaid.

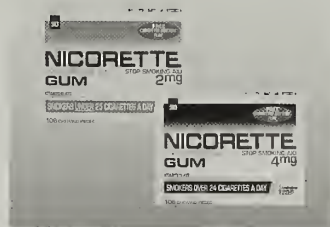
"Contacting Your Legislator" is divided by state. You'll find a photo of the legislator, address, phone, personal bio and political profile. Visitors can also send a message to the legislator. ■

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How to complete an INS exemption form

Immigrants with certain disabilities may be exempted from some citizenship requirements if a doctor diagnoses the impairment.

A new rule, published by the Immigration and Naturalization Service (INS), encourages individuals with certain disabilities to apply for citizenship, exempting them from English, U.S. history and civic requirements.

Medical professionals must complete a form on behalf of an applicant, establishing a "medically determinable" physical or mental impairment (or combination of impairments) that have lasted, or are expected to last at least 12 months.

In order for INS examiners to assess whether or not the individual should be granted the exemption, the form must be completed with the following points in mind:

- The term "medically determinable" refers to an impairment that results from anatomical, physiological or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques to have resulted in functioning so impaired as to render an individual unable either to demonstrate an understanding of the English language, fulfill the requirements for English proficiency, even with reasonable modifications, or demonstrate civics knowledge as required.

- A licensed medical doctor must

complete Part II of a new Medical Certification for Disability Exceptions (Form N-648). This must be done carefully, legibly and in detail.

- Doctors have a responsibility to ensure that they complete the new medical certification form only for individuals whose physical or mental conditions prevent them from meeting the English and civics requirements.

- Question 3 of the form's Part II requires that the doctor be very specific. Provide thorough descriptions of not only the medical name of the condition but also detailed information as to why the condition prevents learning or demonstrating use of ordinary English and the fundamentals of government and civics.

- Doctors should make case-by-case determinations and separate the effect of the applicant's condition on English-language learning from the person's capacity to demonstrate civics knowledge, since a person can have a disability that prevents the demonstration of English proficiency but still allows fundamental learning to take place. In this case, the applicant may be tested in the native language. ■

Take Action

If you have questions or would like more information, contact Judy Marten, U.S. Department of Justice, Immigration and Naturalization Service, (202) 305-4770.

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Contract issues

UR and QA provisions: Clean up vagueness

If utilization review and quality assurance provisions are included in a contract at all, the requirements are often vague or may be outlined in documents that are not available with the contract.

Red flags

These provisions may look something like this:

- "You agree to cooperate with the plan in all health-care management programs and procedures that are a part of the plan agreement."

- "The provider agrees to participate in and cooperate with the implementation and continuing operation of the plan's utilization management program and such other management and quality assurance programs that the plan may, from time to time, develop and implement."

If you find a UR or QA provision in the contract, take care. Complying with these programs without considering the medical impact on your patients may not only sacrifice the quality of patient care, but you will be held responsible for any injury caused to the patient by failure to provide an appropriate standard of care.

Protect yourself

Before you sign any contract, determine whether you will be required to participate in utilization review, peer review, credentialing and/or quality assurance programs.

If so, clarify the following with the plan:

- How many alternative cost-containment and/or quality review programs will you be required to participate in as a result of signing this contract?
- Will you be required to comply with any programs implemented by the payors as well as the plan?
- Obtain descriptions of all cost-containment programs before agreeing to comply with them.
- What information must you submit in order to comply with the programs?
- Are utilization review and appeals processes clearly defined?
- Who may appeal adverse UR decisions?
- Who is responsible for making the final determination in a decision to deny services?

Legislative relief

There are currently four bills pending in the Ohio Statehouse that attempt to make managed-care plans liable for their medical decisions. One of the bills, House Bill 685, requires health-insuring corporations to consult with a "knowledgeable" physician with regard to UR, and House Bill 677, the legislation supported by the OSMA, clearly establishes the accountability of managed-care organizations that result in negligent medical decision-making that results in harm or injury to the patient.

Until managed-care plans are made more accountable through one of these bills, however, you are advised to use caution when signing any contract that features these UR/QA provisions. ■

Take Action

The OSMA Division of Legal Affairs offers members a contract review service. See page 7. For more information about the managed-care bills contact the OSMA Legislation Department at 1-(800) 766-6762.

Surf the Web for latest news

The OSMA Web site (www.osma.org) offers the latest health-care news, upcoming OSMA meetings, seminars and legislation updates including health-care bills introduced, recently passed and currently pending.

In the CME section you can locate continuing medical education activities by location, date and/or activity.

Members can hold conversations with other members by posting questions on the bulletin board. You'll also find helpful links to other Web sites.

If you have suggestions, contact Karen Kirk, ohiomed@osma.org. ■

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Open enrollment begins for HPP

If you're dissatisfied with the managed-care organization (MCO) that is serving your employees in the Ohio Bureau of Workers' Compensation Health Partnership program, you may now select another plan.

An open enrollment period for the program begins April 1 and continues through May 29 for the program year beginning July 1, 1998. The BWC mailed out open enrollment guides and report cards on all participating MCOs to employers on March 23.

You may make a change by either mail or phone.

Physicians are among the 310,000 businesses in Ohio required by the BWC to select an MCO through which employees will receive care in case of a work-related injury. Those who failed to select an MCO by the original sign-up date (Feb. 15, 1997) were assigned to an MCO by the state.

Neither the BWC nor the OSMA can make recommendations on which MCO to select. The report cards, however, contain the overall scores of MCOs based on their performance. ■

Take Action

If you wish to change your MCO, contact the BWC at 1-(800) 644-6292, or write them at the Bureau of Workers' Compensation, 30 W. Spring Street, Columbus, OH 43215.

OSMA offers Aetna info kit

The OSMA Division of Legal Affairs has assembled an information packet for members who may have concerns with their Aetna contracts. Included are talking points, a sample letter to patients that outline the concerns, and a letter that patients can send to their employers. To order a packet call the *Ohio Medicine* reader response line at 1-(800) 766-6762, Ext. 228 and request item #9-98. ■

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May 1998

Ohio Medicine

ODI begins liquidation of PIE

By now, you should have received information from the OSMA regarding the liquidation of PIE Mutual Insurance Company. If you are or have been insured by PIE, you should have received a notice from the Chief Deputy Liquidator of the Ohio Department of Insurance with information on filing claims against the assets of PIE, notice of cancellation of PIE policies and notice of additional hearing dates. If you haven't received this notification, contact: The PIE Mutual Insurance Company, c/o Office of the Insurance Liquidator, 1366 Dublin Road; Columbus, OH 43215, (614) 487-9200.

It's important to note that all PIE policies were canceled as of 12:01 a.m. on April 22, 1998.

If you have not yet replaced your PIE policy, your malpractice coverage has expired. If you have replaced your PIE coverage, you should notify your new malpractice carrier and your lawyer of new and potential claims filed against you after the new policy term begins.

Anyone with a claim against PIE must submit a proof of claim form to the liquidator by March 22, 1999. This includes claims for return of unearned premiums and any other claims against PIE. The ODI has indicated it will mail proof of claim forms to all policyholders within the next three to six months. Requests for proof of claim forms should be mailed to the above address. Once the forms are available, the OSMA will notify members.

For assistance, contact OSMA Senior Director Herb Gillen at 1-(800) 766-6762, and visit the OSMA's Web site (www.osma.org) for updates. ■

Annual Meeting's hot topics: restructuring, E&M guidelines

When delegates gather for the OSMA's Annual Meeting May 16-17 at the Renaissance Cleveland Hotel, they will consider 38 resolutions as well as a report issued by the OSMA Council that proposes an organizational restructuring of the association.

The Council's report (Report A-98) is based on the recommendations of the Task Force 2000, and will be discussed in a special resolutions committee on Saturday at 2:30 p.m.

In addition to the restructuring, delegates will consider resolutions that cover a broad range of subjects, from public health issues, like warning students about the hazards of tanning (34-98), to current legislative topics, such as the new Advanced Practice Nurses Act (08-98) and mental health parity (09-98).

The recent liquidation of the PIE Mutual Insurance Compa-

ny, HCFA's proposed changes in the revised documentation guidelines for the Evaluation and Management services; and the prompt payment of medical claims will be discussed in a series of resolutions presented to the House. ■

Take Action

If you have questions about the OSMA Annual Meeting or need further information about this year's new streamlined format, contact Susan Paulus, 1-(800) 766-6762, Ext. 115. For a sneak peek at this year's resolutions, as well as the Council report, check out the OSMA Web site, www.osma.org.

Aetna cancels meeting

Aetna/US Healthcare canceled the April 6 meeting with the OSMA to review contract terms, on grounds that "antitrust and other concerns prevent us from negotiating provider contract terms with the OSMA."

In a letter responding to OSMA concerns, Aetna reiterated its position regarding coverage decisions, patient confidentiality and gag clauses.

Aetna did indicate it would revise the definition of "emergency services" in Ohio provider contracts to reflect its policy that emergency department coverage decisions will be based on the prudent layperson standard. ■

Take Action

For a copy of Aetna's response to the OSMA letter, contact the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item #10-98.



Congrats offered as PHPPA signed into law. Gov. George V. Voinovich (center) congratulates OSMA and Kaiser officials as well as legislative representatives on the passage of the Physician-Health Plan Partnership Act, shortly after he signed the measure into law. This month, *Ohio Medicine* begins a regular column that looks at specific advantages this new law offers you. (See page 8.)

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Bills, Laws & Rules

Mental health parity bill says who can diagnose

The provision was added primarily as a means to determine which mental health costs would be covered.

Ohioans should have mental health parity, says Rep. Lynn Olman (R-Maumee), who has introduced a bill (House Bill 718) that would expand insurance coverage to include mental illnesses.

Last year, Rep. Charleta Tavares (D-Columbus) introduced her own mental health parity bill (House Bill 420), supported by the OSMA. However, that bill has been locked in the House Insurance Committee, and with Rep. Tavares making a run for the position of secretary of state, Rep. Olman introduced his own legislation to renew interest in the subject.

House Bill 718, Rep. Olman's bill, is similar in most respects to HB 420.

"One difference is that the new bill will specify who can diagnose patients," says Nick Lashutka, associate director, OSMA Department of Legislation.

According to S.R. Thorward, MD, president of Harding Hospital in Wor-

thington, and a key party in developing the bill, the provision was added by the insurance industry primarily as a means to determine which mental health costs would be covered by payors and employers.

The bill specifically names the following professionals as those authorized to diagnose and treat "severe mental illnesses":

- Psychiatrists
- Psychologists
- Professional clinical counselors and professional counselors
- Independent social workers
- Clinical nurse specialists whose specialty is mental health

The "severe mental illnesses" described in the bill are:

- Schizophrenia
- Bipolar disorder (manic-depressive illness)
- Major depression
- Panic disorder
- Obsessive-compulsive disorder

• Schizophrenic disorder

Like HB 420, Rep. Olman's bill mandates that each individual or group health insurance contract regulated by the Ohio Department of Insurance provide coverage for the illnesses named. This broadens the scope considerably from the federal mental health parity act which extends mental health parity only to those individuals who already have mental health coverage (see related story.)

House Bill 718 has received support from legislators, mental health professionals and Virginia Haller, MD, medical director, Ohio Department of Health.

"The OSMA supports both this bill and HB 420," says Lashutka.

Despite the new attention to the subject, however, more pressing legislative issues, coupled with an election year, make it unlikely that Ohioans will see mental health parity anytime this year.

Ohio Medicine will keep you posted. ■

What about federal mental health parity?

Congress passed the Mental Health Parity Act in 1996, which became effective for employer-sponsored health plans that began on or before Jan. 1, 1998.

The law requires employers who already offer mental health coverage to provide the same annual and lifetime dollar limits for coverage of mental health illness coverage as it does for physical health/medical coverage. No where in the law, however, does it state that employers must offer mental health coverage to employees.

There are further limitations in the federal law as well:

- It applies only to employers with 50 or more employees.
- Benefits for substance abuse and chemical dependency are excluded.
- If the law increases the cost of a group health plan by 1% or more, and employers can provide evidence that it does, they may claim an exemption from the law.

Two bills that are currently in the Ohio Legislature on this subject extends the mental health parity mandate to all insurance plans except those that are self-insured. ■

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Pharmacists who enter consult agreements with physicians may modify the prescription with respect to dosage and form for certain patients, but they may not make therapeutic substitutions.



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Doctors' Company was forced to chart a new course in Ohio when its partner-to-be, the PIE Mutual Insurance Company, was placed in liquidation by the Ohio Department of Insurance.

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Meet the candidate for OSMA President-Elect. David Ulak, MD, Conlon, provides insight into his motivation to seek office, and goals he'll set if elected.



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Billing services are among the "hot targets" the Inspector General is looking at in 1998. Make certain you're dealing with a reputable company before using their services.

Those tapped for CME audit need to hold on to records

Current rules regarding continuing medical education (CME) state that physicians must keep their CME records for one year – a time frame that sometimes presents a problem when the board proceeds with a CME audit. That's because the audit period may extend over the one-year time frame.

For that reason, the board is proposing to change the rule so that, if the board taps a physician for a CME audit, the physician will be required to keep his or her CME records until the completion of the auditing process. If the physician receives no notice of an audit, records may be discarded after one year.

The proposed revision also spells out, for the first time in rules, the requirements for Category I and Category II CME, and also provides details of the type of proof the board considers good evidence of Category I and II completion.

Of note...

Midwifery seen as practice of medicine...Despite a report from the Direct Entry Midwifery Study Council which proposes legalizing the status of lay

midwives (see article on page 7 for more information), the board (as well as the OSMA) has taken a minority position on the issue. Board member Carol Egner, MD, served as that agency's rep-

Medical Board Report

resentative on the council, and in a letter responding to the council's final report, she states the board sees midwifery as the practice of medicine and if lay midwives are to be recognized, as the legislative study panel suggests, they should have the same training, education, licensure and scope of practice as exists for advanced practice nurses who serve as nurse-midwives. The board also believes that prescribing and using drugs, such as Pitocin, requires extensive medical education and training and, because it is the practice of medicine, requires licensure.

Laser use under discussion...Both the board's Minimal Standards of Care Committee and its Scope of Practice Committee have discussed the growing use of laser procedures and whether or not their use constitutes the practice of medicine. Discussions were triggered in both committees by a letter from a physician who asked the board for information regarding regulations that would allow nurses to operate lasers under the direct supervision of a physician. Since the Nurse Practice Act does not address the issue, the doctor wanted an opinion from the board. He added that the Ohio Board of Nursing told him that registered nurses can do anything that falls under the scope of their training, as long as it is not illegal and they work under a physician's supervision. The board decided to inform the physician that the use of a laser is a surgical technique and it, therefore, considers the use of lasers to be the practice of medicine. However, discussions on this topic are still under way at the board and that decision could change in the future. ■

Bill to guide therapists on "duty to warn"

Last year, in *Morgan v. Fairfield Family Counseling Center*, the Ohio Supreme Court handed down a decision that says a psychotherapist who knows or should know his or her client presents a substantial risk of harm to others, has a duty to warn the third party.

The mental health community, however, wanted guidance on how and when to present the warning, so two bills have been drafted that establish such guidelines.

House Bill 699, sponsored by Rep. Jack Ford (D-Toledo) and House Bill 717, sponsored by Rep. Rose Vesper (R-New Richmond) both cover the same subject and are similar in scope, but the latter bill is supported by mental health professionals as well as by the OSMA.

The Supreme Court's decision is far-reaching. The therapist's duty to warn third parties arises even if there are no specific threats and no identifiable potential victims. Even if treatment ended, the therapist is still obligated to warn, under the decision.

House Bill 717 establishes guidelines for when the duty to third parties arise, and how to discharge the duty; presents options to meet the duty; and provides that, if a therapist has taken any of the actions named in the bill, and the patient proceeds to harm the third party anyway, the therapist will not be held liable in a civil action or made subject to disciplinary action. ■

Take Action

If you have questions on HB 717, contact Nick Lashulka, associate director, OSMA Department of Legislation, 1-(800) 766-6762, Ext. 226.

Newborn testing may be revised

Working with the cooperation of the Ohio Department of Health (ODH), Sen.



Grace Drake (R-Solon) has introduced a bill that revises the law regarding newborn screening tests.

The measure, Senate Bill 241, is an attempt to modernize and streamline the screening procedures performed on Ohio's newborns, says Virginia Haller, MD, medical director of the ODH.

"Some of the tests we perform are now

longer state-of-the-art," she says. "We don't want to provide test results to parents that are meaningless or, worse, provide false information."

Tests won't be dropped arbitrarily, Dr. Haller assures. "It may be a trade-off.

We added the hemoglobinopathy test because we learned we can treat it effectively at three months with penicillin." The test for homocystinuria may be dropped, however, because it must be tested for 48 hours after birth, a time after most infants have left the hospital, and because the disorder itself is so rare.

Yet, as current law stands, homo-

cystinuria is one of the disorders ODH is required to screen for. The legislation would eliminate the specific mention of disorders that must be screened for and, instead, allow the state's Public Health Council to compile a list of screening tests based on such factors as availability of effective therapy and expected benefits to parents and children. Dr. Haller doesn't expect the screens for the other four disorders Ohio newborns are tested for to change, even if the bill passes.

"The legislation would give us more flexibility on what tests are conducted," says Dr. Haller. It would also clarify the definition of screening as opposed to testing. "We don't conduct true tests," says Dr. Haller, "so the bill would clean up that language." ■

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Physicians, pharmacists may now enter "consult agreements"

These agreements will allow pharmacists to modify the physician's prescription with respect to dosage and form.

With the passage of Senate Bill 66, sponsored by Sen. Grace Drake (R-Solon), physicians can now enter into consult agreements with pharmacists. These agreements will allow pharmacists to modify the physician's prescription with respect to dosage and form, but the bill expressly prohibits therapeutic substitution.

"These agreements are primarily for the benefit of chronically ill patients who are on long-term drug therapy," says Marla Eshelman Bump, associate director, OSMa's Department of Legislation. "And there are limits on the

agreements." For example, the pharmacists cannot change the drug that is identified in the consult agreement, and each agreement is entered on a per-patient, per-prescription, per-diagnosis basis.

Before the bill passed, an amendment was added which allows pharmacists to use their judgment in dispensing up to a 72-hour supply of drugs to a patient when the prescribing physician is unavailable. The amendment, offered by Rep. Vernel Whalen (D-Cleveland), is meant to address weekend emergency situations on those occasions when patients on maintenance drugs find themselves in need of a refill but are unable to reach their physician.

In order to qualify under the amendment, the patient must have a prescription on file, and drugs would be dispensed only to chronically-ill pa-

tients or in life-threatening situations. The pharmacist would also be required to notify the physician within 72 hours of dispensing the drug and would have to maintain records for one year from the date he or she dispensed the medications.

Although the OSMa had not taken a position on this bill, instead keeping the measure under advisement, the association's Legislation Director Tim Maglione urged legislators to exercise caution before adopting the amendment. He asked them to consider if the decision to dispense drugs, even in emergencies, is the responsibility of the pharmacist or physician. He suggested that a list of appropriate drugs could be drawn up that would be dispensed in emergencies or that information could be placed in the consult agreement between physician and pharmacist. Nevertheless, the amend-

ment passed.

Bump says the consult agreement may be initiated by any of the parties involved – the physician, the pharmacist or the patient. She adds, however that the patient must be informed and consent to any agreement between physician and pharmacist before a consult agreement is put into place. ■

Take Action

If you have questions about the new law, or about the consult agreements established by Senate Bill 66, contact Marla Eshelman Bump, associate director, OSMa Department of Legislation, 1-(800) 766-6762, Ext. 222.

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Proposed "list" would separate dangerous drugs

Because some drugs are difficult to manage and can be dangerous if interchanged with different brands or generic equivalents, Rep. Richard Hodges (R-Wauseon) has introduced a bill (House Bill 633) that would set these potentially hazardous drugs apart and require pharmacists who refill prescriptions for these drugs to receive the prescribing physician's permission before dispensing another brand or generic equivalent.

"This has to do with narrow therapeutic index drugs like Coumadin," says Krista Bistline, OSMa Department of Legislation, who is monitoring the bill.

Under the measure's provisions, the State Board of Pharmacy would establish a list of these drugs in consultation with physicians. Patients would also have to be informed about the dangerous nature of these drugs.

"Physicians will have final say in what drugs are dispensed to the patient," says Bistline. "Also, we have asked for clinical peer language so that appropriate specialties will review certain medications. For example, we would like to see pediatricians decide what pediatric medications belong on the list."

The OSMa Committee on State Legislation recommended a position of support on the measure. The OSMa Council adopted the recommendation in March. ■



Panel recommends legalizing lay midwives

The OSMA wanted to prohibit the practice unless the midwife could demonstrate education equivalent to nurse-midwives.

The practice of lay midwifery should be legalized in Ohio, says a report issued by a legislative study committee, and all legal ambiguities surrounding the practice should be clarified.

The Direct Entry Midwifery Study Council, which issued the report, was created by the Advanced Practice Nurses Act two years ago. Although that law recognized the status of nurse-midwives, there were no clear rules regarding the status of those who deliver babies but who are not nurses. The panel's charge was to examine whether or not these "lay midwives" should be outlawed or at least be regulated in Ohio.

Instead, the group's final report, submitted in March, calls on legislators to craft a bill that legitimizes the practice and gives greater freedom of choice to parents who want their babies delivered by someone other than a health-care professional.

Physicians should be the ones delivering babies

"We're disappointed by the report," says Marla Eshelman Bump, associate director, OSMA Department of Legislation. "We think physicians are the professionals best qualified to deliver infants. There are a number of risks and complications that may occur during delivery, and doctors have the education and training necessary to handle such crises."

Donald K. Bryan, MD, who served as OSMA's representative on the panel; Carol Egner, MD, the representative from the State Medical Board of Ohio; and Mary Ann Rosencrans, representing the Ohio Board of Nursing, all voted to prohibit the practice of lay midwifery unless the midwife could demonstrate competencies, education and training equivalent to a certified nurse-midwife. (Nurse-midwives are

advanced practice nurses who, beginning in 2001, will need a master's degree to qualify for the duties of nurse-midwife.)

Dr. Bryan also pointed out to the committee that statistics and studies have shown that hospitalization and increased education are the reasons for a worldwide decrease in maternal and neonatal mortality.

"We, as protectors of public health, should not be recommending legislation that is counter to this," he says, adding that the panel's recommendation for "mere registration" of anyone who would like to perform a delivery, "is not in the best of interest of the safety and welfare of mothers and babies."

Those favoring legalization were: Sen. Merle Kearns (R-Springfield); Sen. Rhine McLin (D-Dayton); Rep. Joan Lawrence (R-Galea); Rep. Ver-mel Whalen (D-Cleveland); Christopher Celeste and Holly Christensen, consumer advocate members; Abby Kinne, lay midwife; and Nancy K. Lowe, certified nurse-midwife.

Voluntary registry recommended in report

The panel's report also recommends a voluntary registry for direct entry midwives be established at the Ohio Department of Health or local health boards that would be made available to the public; and informed consent forms be developed that would educate the parents on the practice of lay midwifery and protect the midwife from liability.

"The panel's final report is just a series of recommendations," says Bump. "There would have to be proactive steps taken to make the practice of lay midwifery legal in this state. So far, we haven't seen that happen, and probably won't this year. Could it happen in the future, maybe even next year? Yes, it might." ■



Alliance members become volunteer legislative workers. OSMA Alliance President Denise Kneisley, left, shares a light moment with Melissa Harwood, legislative aide to Sen. Merle Kearns (R-Springfield). Kneisley, along with seven other Alliance members, participated in a pilot project in March in which Alliance members served as volunteers in legislators' offices. Other participants included: Joy Myers, Circleville; Jan Kirlin, Cincinnati; Amy Han, Hamilton; Myra Cachran, Painesville; Nancy Stienecker, Wapakoneta; Bunny Johnson, Columbus; and Sara Rich, Dayton. See the Alliance Report on page 13.

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The PHPPA Advantage

Grievance procedures required

Editor's note: The Physician-Health Plan Partnership Act (PHPPA), sponsored by the OSMa and Kaiser Permanente, passed last year and becomes effective in October. Yet many physicians aren't fully aware of the benefits this new law offers both you and your patients. This month, Ohio Medicine begins a monthly column to familiarize you with the law's provisions, and with your rights under a managed-care environment.

Before PHPPA passed, there was often little recourse for physicians who determined a course of treatment for a patient, only to see that recommendation denied by a plan during prior authorization requests or utilization review procedures. Some plans might have appeals processes in place but other plans did not.

"One of PHPPA's goals was to raise the standards of all health plans to a minimal level," says Tim Maglione, director, OSMa Legislation Department.

In terms of an appeals process, the Physician-Health Plan Partnership Act accomplishes this in two ways:

1. All plans are required to have a defined grievance procedure in place to handle appeals for treatment denials.

2. All appeals will be heard by clinical peers.

In other words, if a cardiologist recommends heart surgery and the treatment is denied by the plan, any appeal that is made will be heard, ultimately, by a cardiologist drawn from the plan's panel. "This clinical peer review will assure that physicians with specialized training will be reviewing UR requests," says Maglione.

A final note: This provision also allows patients to seek the advocacy and counsel of their physicians without concern of retaliation against either the patient or the physician. ■

Take Action

For more information on this provision of the PHPPA, or on the full law, contact Tim Maglione, OSMa Department of Legislation, 1-(800) 766-6762, Ext. 220, e-mail: moglione@osmo.org. If you would like a copy of the PHPPA Executive Summary, prepared by the OSMa Legislation Department, contact the Ohio Medicine reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item #12-98.

Illegal disabled parking permit? You could be liable

Legislation has been proposed that will stiffen penalties for those who park in

handicapped spaces illegally. And here is where physicians who attest to the need for handicapped permits come in: The bill will require physicians to send the Ohio Bureau of Motor Vehicles (BMV) a prescription that states the disability or reason for the permit, and makes it a first-degree misdemeanor for a physician to knowingly falsify such information.

The measure, not yet introduced, will be sponsored by Rep. Bryan Williams (R-Akron) and Rep. William Schuck (R-Columbus) and will raise fines for parking illegally in a handicapped location from \$100 (the current cap) to between \$250 and \$500.

The bill is meant to stem what is perceived to be an explosion in unneeded disabled parking permits. The legislation will also require expiration dates on display placards. ■



Quick news...

• **Managed-care accountability bills on hold...**The trio of House bills addressing managed-care accountability have been referred to a subcommittee of the Civil and Commercial Law Committee for study. A five-member panel will consider House Bills 641, 677 and 685, all of which propose to make managed-care organizations responsible for the medical necessity decisions they make, especially if that decision results in harm to the patient. It's unlikely the special subcommittee will reach any conclusions or issue any reports about the bills until next year.

• **Bill expands defibrillator use...**Rep. Rose Vesper (R-New Richmond) has introduced a bill (House Bill 717) that not only expands the use of automated external defibrillators but also provides those who use the devices the same immunity protection provided individuals who use CPR in emergency situations. The bill is in the Health, Retirement and Aging committee.

• **Abortion notification effective May 6...**Physicians who perform abortions are now required to meet with a woman at least 24 hours before her abortion to inform her about the procedure and to answer any of her questions. House Bill 421, which was signed into law earlier this year, also forbids doctors from performing an abortion on a minor without consent of a parent, proof the minor is emancipated, or a court order authorizing the abortion. The minor must give her informed consent as well.

• **Anesthesia bill update...**The OSMa has taken a position of support on House Bill 392, the legislation requiring that certified, registered nurse-anesthetists be supervised by anesthesiologists. The OSMa had formerly kept the bill under advisement.

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Dateline Ohio

Studies continue on Marion leukemia rate

Ohio Department of Health (ODH) researchers continue to study cases of leukemia in Marion County in an attempt to determine if the city's leukemia rate rose in the years between 1992 (the state's first reporting year) and 1996.

Last October, ODH researchers, led by Robert Indian, an epidemiologist with the department's Ohio Cancer Incidence Surveillance System, issued a report which examined the high leukemia rate reported among graduates of River Valley High School in Marion. The high school and the city's middle school are on or near property used by the U.S. Defense Department to store bombs during World War II.

Scope of study broadened

Although the state determined a need to rule out the schools as a potential source of exposure to hazardous materials, researchers, along with city health commissioners agreed to broaden the scope of their investigation to

the entire community rather than just the school.

Researchers found a marked increase in leukemia mortality (122%) for residents of the City of Marion for the period between 1986-1995. The rates decreased 30%, however, for residents of Marion County who live outside of Marion.

While the rise in leukemia rates for residents of Marion (city) may be due to random chance, researchers also concluded that environmental carcinogens, including radioactive substances and dangerous chemicals, may play a role in the increased leukemia rates.

Samplings taken for analysis

The following recommendations were made:

- If private wells of leukemia decedents are present, the wells should be tested for radium and other toxic substances.

- The local water system should also be tested for radiological or other

harmful substances.

- Test results from the school grounds and former depot storage grounds (including those on private property) should be reviewed for hazardous substances and radiological contamination.

- Additional epidemiologic studies of newly diagnosed leukemia cases in Marion should be made in an attempt to determine risk factors.

Study ongoing

The samplings will not show causes of any of the previous leukemia cases, researchers note, but they will help evaluate whether or not environmental carcinogens pose any current risk.

Meetings are held periodically with Marion residents to update them on the investigations. Cancer-causing chemicals have been detected in the soil around River Valley High School, and the Army Corps of Engineers, responsible for cleaning up military waste, have taken over the investigation on school grounds because it served, formerly, as the site of the military depot.

Meanwhile, Indian and his research team have begun a new study that will determine the current incidence of leukemia in the city. Once that is determined, he will use the 1992-96 data to map out the areas where leukemia deaths occurred in the county to arrive at a clearer picture of Marion's present leukemia rate. ■

Take Action

If you would like a copy of the October 17 report, issued by the Ohio Department of Health, contact the Ohio Medicine reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item #13-98.

Seniors find help with insurance forms

If you currently treat older patients, you should know that the Ohio Department of Aging, along with the Ohio Department of Insurance, now operates a statewide program that answers seniors' questions about health insurance.

OSHIP, the Ohio Senior Health Insurance Information Program, began as a state initiative six years ago, but was initially located in just a few areas of Ohio. OSHIP now has information sites in all 88 counties.

You may advise your patients, who may be confused about their health insurance, to call the toll-free help line, 1-(800) 686-1578, where trained counselors can help answer their questions.

In addition to help through OSHIP's help line, seniors may also ask for:

- **Free literature.** Ohio and the U.S. government have produced many easy-to-read guides on Medicare, long-term care insurance and other health programs for seniors. Along with OSHIP's *Ohio Shopper's Guide to Medicare Supplement Insurance*, the Ohio Department of Aging also has available two new guides to help older Ohioans better understand Medicare HMOs.

- **Personal visits.** Volunteers can meet with the senior in person, in their own home.

- **Group presentations.** OSHIP trainers are available to speak to groups at senior centers, community centers, public libraries and other venues.

- **Internet address.** Computer-savvy seniors can visit OSHIP through the Ohio Department of Insurance's Web site, www.state.oh.us/ins. If you want to check it out first, you can visit the OSMA's Web site, www.osma.org and link to the ODI site from there. ■



Pediatric fellow honored for community service. John Racadio, MD, right, a fellow of Pediatrics at Children's Hospital Medical Center in Cincinnati receives the AMA/Glaxo Wellcome Leadership Award from AMA President Percy Wootton, MD, recognizing his outstanding community service. Dr. Racadio served as chair of his fraternity's community service committee at Stanford University and organized dinners for a local retirement home and summer sporting events for underprivileged children. He also has coached baseball for an inner-city youth league. He is one of 40 resident physicians honored by the AMA.

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May

Date: May 13
Time: 8-9 a.m.
Hours: 1.0
Title: Common Sports Related Injuries
Where: Robinson Memorial Hospital,
Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

Date: May 14
Time: 1-6 p.m.
Title: Colposcopy for the Primary Care
Physician
Where: Mount Carmel Health System,
Columbus
Sponsor: Mount Carmel Health System
Contact: Cynthia Kemp, (614) 234-
5351

Date: May 20
Time: 8:30 a.m.-5:30 p.m.
Hours: up to 7
Cost: \$95
Title: 2nd Annual Mexican-American
Binational Course in Respiratory Dis-
eases: Respiratory Infections
Where: University Hospitals/Cleveland
Forum Conference Center, Cleveland
Sponsor: University Hospitals
Contact: CME Registrar, (216) 844-
5050

Date: May 27
Time: 8-9 a.m.
Hours: 1.0
Title: Childhood Depression and Related
Disorders
Where: Robinson Memorial Hospital,
Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

June

Date: June 3
Time: 8-9 a.m.
Hours: 1.0
Title: Antibiotic Therapy in General
Practice/Acute Care and Bacterial Re-
sistance
Where: Robinson Memorial Hospital,
Ravenna
Sponsor: Robinson Memorial Hospital
Contact: Pat Dias, (330) 297-2540

For further CME opportunities, check
the OSMA's Web site, www.osma.org

Depth Report

Doctors' Company wants consideration on its own merits

When the Ohio Department of Insurance announced it would liquidate the PIE Mutual Insurance Company, PIE's partner-to-be, The Doctors' Company was forced to chart a new course in Ohio.

PIE Mutual Insurance Company has been liquidated according to court orders. Now, Richard Anderson, MD, chair of the Board of Governors of The Doctors' Company (TDC) — PIE's former partner-to-be — wonders whether PIE's liquidation could affect the reputation of TDC. He hopes not, but he's concerned by the maelstrom of misinformation and confusion that has spun from the Ohio Department of Insurance's (ODI) announcement it was folding PIE.

"I was in Ohio when news of the ODI's rehabilitation action against PIE was released," he says several weeks after a court order disbanded the carrier. "There was anger and astonishment, and physicians were asking why we didn't know about PIE's serious financial state since we had entered into an alliance with the company. While TDC was greatly concerned about PIE's finances from the beginning of our discussions with them, we thought it would be possible to structure an agreement, approved by the ODI, that would allow an orderly transfer of their policyholders to TDC, on renewal dates." But in the course of fulfilling their regulatory duties, the ODI determined it would be appropriate not only for PIE to cease issuing new policies, but also to cease renewing policies. This meant TDC had to accelerate its schedule and prompted many doctors to seek new carriers immediately.

PIE candid about difficulties

During negotiations, PIE admitted concern about its financial distress and its long-term financial viability, says Dr. Anderson. But the fact it was having money problems also meant someone would have to provide Ohio doctors with a safety net. "We saw that Ohio doctors were going to need to change carriers, and we wanted to expand our presence in Ohio," says Dr. Anderson.

"We recognized that PIE would have to cease issuing new policies and it was our intention to assimilate every PIE policyholder on renewal," he continues.

Rates higher for reason

TDC offered these physicians guaranteed coverage — but at Doctors' Company rates. TDC rates are higher than PIE rates for a good reason, says Dr. Anderson. The Doctors' Company has an unblemished record and an "A" rating from A.M. Best, one of the companies that rate insurance carriers. "We achieved our financial strength and stability by offering responsible rates," says TDC President Manuel S. Puebla. "We meet our obligations — the liabilities of our insureds — by adhering to the basic insurance principle that premium income must be adequate. This opportunity did not present an exception to the rule, instead it proved it," continued Puebla. According to Dr. Anderson, TDC had already concluded that PIE's deeply discounted rates were not sustainable in the marketplace.

"We knew there was a hole," says Dr. Anderson, referring to PIE's financial health. "But not how deep it was. We made a good-faith effort to serve the physicians in Ohio."

Similar cultures shared

"We respected the physician-oriented culture of PIE. Our companies shared similar histories with the same guiding principle that medical knowledge is crucial to effective liability coverage. We could also appreciate the deep affiliation that PIE doctors had with their carrier. There was nothing wrong with that," says Dr. Anderson. "But we also understand the feeling of betrayal that former PIE policyholders have experienced. There was loyalty to a company that let them down."

The Doctors' Company is committed to a long-term presence in Ohio. Already, TDC has opened a full-service Ohio office in Cleveland, its agents blanket the state, and the carrier is currently negotiating with attorneys who staffed Jacobson, Maynard, Tuschman & Kalur, the law firm formerly affiliated with PIE, to handle its claims.

"We are committed to Ohio long term," says Dr. Anderson. Within a few short months, Ohio has become TDC's second-largest state. "We've never left a state we've entered," he adds. "The only obstacle in TDC's path now may be the continuing 'soft' market in which underpriced insurance is still available."

"Before this occurred, PIE had our recognition and respect," says Dr. Anderson. "We were going to bring together the best of The Doctors' Company and PIE."

Now, he says, he trusts Ohio physicians will consider The Doctors' Company on its own merits. ■

Doctors' deal with PIE

At the time The Doctors' Company began negotiations with PIE Mutual, TDC was already a presence in the state, although a small one. Dr. Anderson estimates only 300 Ohio physicians held policies through TDC, a number dwarfed by the 8,000-9,000 physicians enrolled on PIE's books.

Last year, when PIE approached TDC about a possible alliance between the two companies, Dr. Anderson acknowledged, "We were willing to make the commitment." He hastens to add, however, that at no time did any official at TDC offer to buy PIE nor did TDC ever say it would assume PIE's liabilities. "We had no way of knowing what those liabilities were," explains Dr. Anderson.

Instead, under terms of its agreement with PIE, TDC offered PIE policyholders TDC coverage beginning on their renewal dates, and assumed responsibility only for claims made under its newly issued policies.

PIE's arrangement with TDC also called for the Doctors' Company to pay PIE not only for its services, but a fee for its transfer business as well. PIE was to use this money to offset operating costs, including claims arising from PIE policies. "By providing PIE with a share of the premiums generated, we thought we would mitigate any possible future shortfall PIE experienced," says Dr. Anderson. "No other carrier could say that." More than 2,000 PIE policyholders were transferred to TDC under this arrangement, but the money was too little, too late. Dr. Anderson is now skeptical whether or not the \$11.5 million in unauthorized payments allegedly made to three PIE executives shortly before the company collapsed would be enough to resuscitate PIE, even if the money was recovered. In fact, in February, the ODI concluded that PIE was about \$300 million in debt. ■

OSMA News

Meet the candidate

Dr. Utlak promises to listen, then steer



Q. What motivated you to run for the office of OSMA President-Elect?

A. I have always believed that it's appropriate and good to give something back to the profession that has given so much to you. Beyond that, however, I think it's important for all of us to be active in our community and our profession, and by active I mean involved in the issues that are pertinent to the time within which you live. I've always been interested in the issues that face our profession, and how those issues, and the profession, itself, fit into the world. That interest has been the basis of my motivation to run for this office.

Q. What qualities do you possess that make you eligible for the job?

A. I've been blessed with an above-average amount of energy that has enabled me to do a variety of different things, all at the same time. For example, in college, I participated in three varsity sports while completing a pre-med course of study. I'm used to coping with the stress of doing a lot of different things at once, and I think that's an important quality — not only because the leader of a state professional association must deal with an assortment of issues and priorities, often simultaneously, but also because these individuals need to maintain an active practice at the same time.

I think my intellectual background also qualifies me for this undertaking. By that, I mean I have always strived to read history, political philosophy, economic theory and general philosophy that all put the world into perspective. In fact, I co-founded a book club 14 years ago that still meets monthly to discuss the ideas and philosophies raised in our readings. We don't live in a vacuum and medicine is not the only world in which we live. Don't get me wrong. I love medicine. I love taking care of patients and pursuing the challenges that medicine presents, but I

think it's important for us to be able to converse fluently with those in other professions and businesses. I've always been involved in the "business" as well as the professional side of medicine. That's what enables an individual to meet and talk with other professional and business leaders on their terms.

Q. What goals would you set as OSMA President?

A. First, I would try to steer the OSMA through the significant changes that the association, and all associations, are going through at this time. Members today don't feel as dedicated to their associations as they did. They don't perceive the need for the association. As president, I would like to help change that perception.

Second, and this is controversial, but I would like to begin to address the issue of the ethics and the business of practicing medicine. I think the two are not mutually exclusive, and that you can combine the two into a good health-care delivery system. We've done a good job of advancing the science and art of medicine but what we haven't done very well is to put together a system to deliver health care to large populations. That kind of effort really needs to be led by our profession, because if we don't do it, someone else will. We need to be proactive in this regard, not reactive. Physicians need to take a leadership role in this area, and that sometimes means changing the way we do things. That's not always popular, in fact, it's controversial. But I've never been afraid of new ideas or controversies and the challenges they provide.

Q. What do you think will be the most pressing issues for the association?

A. Membership retention; challenges to our new tort-reform law; and the frustrations over government's demand for quality and efficiency, as exemplified in the proposed E&M documentation

guidelines. This last illustrates a problem that is a waste of time for us and a detriment to our patients. The AMA and the OSMA have clearly heard the grass-root objections to this proposal. As president, I hope to help our profession deal with, or learn to cope with, these changes. If we are to succeed in putting our patients first, we need to lead in issues such as these.

Q. Has managed care affected membership in organized medicine?

A. Without a doubt. Physicians are feeling the pressure of decreased security and income as a result of managed care, and that pressure has driven doctors to look more closely at the dues they pay. As a result, more and more doctors turn away from their professional associations. However, I think the OSMA has been responsive to the managed-care pressure our members feel. For example, we introduced the Physician-Health Plan Partnership Act and continue to follow through on various patient rights legislation. We are trying our best to respond to our members' needs, especially in this rapidly-changing marketplace.

Q. How would you make the OSMA into a cohesive unit that represents all of Ohio's physicians?

A. Despite our differences, we still have common goals, concerns, ethical and business interests, and it is up to the leadership to articulate them. We still need to be able to speak on behalf of our patients, and on behalf of our profession and it's best that we do that with a unified voice. That doesn't mean, however, that I will assert my goals without first listening to other views. I consider myself fair. I want to hear the different sides of an issue before deciding which direction to take. I think that's another quality that makes for good leadership. First, you listen. Then you steer the ship. ■

Members surveyed on dues

Late last year, Ohio physicians were surveyed by the OSMA to determine whether or not the association could be more responsive to their needs in a changing marketplace. More than 500 doctors, 200 in Cuyahoga County, 350 in the rest of the state, were interviewed by telephone. The group included members, former members and nonmembers. Here are a few of the results:

- Members as well as nonmembers prefer that county and state society dues be separated instead of linked.
- Reduced fee arrangements, such as group practice single-fee arrangements, were favored by the majority.
- About one-third of those surveyed say that the negative effect managed care has on their finances affects their membership choices.
- Survey participants say organized medicine, including the OSMA, needs to take an aggressive stance on a wide range of managed-care issues. Still, 30% feel that kind of action would be inappropriate for a professional organization.
- Specialty societies rank higher in perceived value than general membership medical associations.
- The OSMA might do better to retain existing members and increase perceived value of the OSMA before attempting to attract former members and nonmembers. ■

Take Action

For a copy of the full report, contact Jamee Patton, OSMA Membership Department, 1-(800) 766-6762, Ext. 106.

All good things must end

All good things must end, and it's my time to pass the gavel to my successor, Nancy Goorey, DDS. She will be a wonderful representative and leader of the Alliance. Before I go, however, I'd like to say thank you, and share a thought or two.



Denise Kneisley

It has been an honor and a pleasure to work with OSMA's fine leaders and staff. Drs. Kang, Talmage and the members of Council have all been supportive and encouraging throughout the year. OSMA members can feel confident that they are in good hands with this team.

As for the organization of OSMA, your best partner, biggest supporter and best friend is the OSMA Alliance. We have provided a legislative voice on behalf of medicine and physicians, we have provided health career scholarships to ensure quality health prac-

Alliance Report

tioners for the future, we have contributed back to our communities many dollars for health programs in the name of medicine, and we have taken huge steps in providing information and education in the prevention of domestic violence and child abuse.

The Alliance — your Alliance — has worked hard to keep the image and respect of medicine high. When you are looking for allies, friends and supporters, just look over your shoulder to your "partners" in preserving quality medicine. We'll be there for you.

Thank you for a wonderful year. Best wishes for a successful future with OSMA. ■



Immigration, managed care among topics at IMG meeting. International Medical Graduates (IMGs) convened near Cleveland in late March to learn more about immigration law, J-1 Visa policies, and managed-care issues. The topics were part of an IMG program, sponsored by the OSMA and its IMG Task Force, in cooperation with the OSMA's component county medical societies in Northeast Ohio. Pictured here are (left to right): Vasu Pondrangi, MD; Carmencia Damian, MD; Busharat Ahmas, MD; OSMA President Su-Pa Kang, MD; and Andres B. Lao, Jr, MD.

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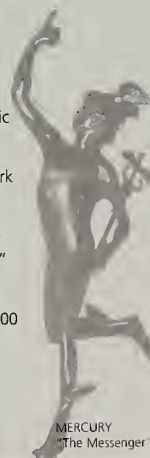
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President's Perspectives

Surviving the tiger's den with help from my friends

By the time you read this column, I will be at the end of my term of office as president of the OSMA. Since beginnings and endings always provide an opportunity for reflection, I have spent some time, lately, looking back on all that has happened during my tenure.

In my first presidential column (June 1997), I recalled the advice of my father, a Korean freedom fighter, who said, "To catch a tiger you have to enter the tiger's den."

Su-Pa Kang, MD

Looking back on my year, I can identify a number of times that we, in fact, have entered that den. One example that springs to mind is the OSMA's successful managed-care reform campaign. Along with Kaiser Permanente, we supported the bill that became known as the Physician-Health Plan Partnership Act. When the bill was introduced, we entered what could have been a very treacherous den, but we emerged with a new law that greatly benefits you and your patients.

But I admit, as proud as I am of this and all of our efforts this year, it will not be the thing I remember most as I recall my time in office.

What I will remember most is the people — all of you.

I made a point of visiting as many county medical society meetings this year as possible. These occasions provided me with the opportunity to meet face-to-face with hundreds of members. During these meetings, I made a point of keeping my remarks

short so that I would have time to hear from you directly. What I heard made me proud. Regardless of the issues, your dedication to your patients and your profession came through loud and clear. When I left these meetings I felt energized by your confidence and support and buoyed by the knowledge that, as difficult as the problems facing medicine are, much can still be accomplished when all of us work together.

To OSMA officers and counselors, OSMA and AMA delegates and alternates, county medical society presidents, committee members — I can never adequately express how much your advice and support has meant to me this year. Your hard work has benefited both our patients and our profession.

But much credit also goes to the OSMA staff. They work long and hard to represent our interests. Time and time again they tackle the biggest issues on our behalf, and time and time again they are successful in doing so. It was a pleasure working side by side with them this year.

I admit, when I assumed office last year, I was a little anxious. The den looked big and dark and the tiger sounded ferocious. But I didn't know then what I know now: That I wasn't entering that den alone. That with your direction and support, we can capture the tiger.

Thank you.

County society helps form trauma foundation

The Columbus Medical Association has united with other community leaders and hospital representatives from Columbus to form Central Ohio Trauma System Foundation (COTSF). The new foundation will create a local trauma registry to collect and evaluate data and to help develop programs for the care of trauma victims.

Sitting on the COTSF board are representatives from the Columbus Medical Association, all area hospitals, Columbus Health Department, Franklin County Fire Chief's Association, Emergency Medical Service entities, and Franklin County Commissioners.

Officers are: Robert Falcone, MD, president; Kathy Haley, RN, vice president; Henry Barkowski, MD, secretary-treasurer.

To begin the data collection process, CMA Foundation awarded a grant of \$76,450. Additionally, \$5,000 was received from several Columbus hospitals.

COTSF will also develop injury prevention initiatives to increase community awareness of trauma. Committee

County Medical Society News

members of COTSF will address prevention and education, destination protocol and centralized communication, clinical, and autopsy policies.

"Creating an efficient regionalized trauma system will require unified patient registry, and verification and designation processes for trauma hospitals," says Dr. Falcone.

Lake County elects officers

Claudio Gallo, MD, a Lake County vascular surgeon, was elected president of the Lake County Medical Society. Other officers are: Armando B. Damiano, MD, president-elect, Painesville; Jamal Azem, MD, secretary-treasurer, Willoughby. ■

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Practice Tips

Fraud-proofing your practice

Approach billing services with caution

Since billing services are on the Inspector General's "hot target" list, make certain you deal only with reputable services. Here's how to know if the service you use is up to the scrutiny.

When it comes to fraud and abuse investigations, the Office of the Inspector General (OIG) is looking closely at physician billing practices—not honest billing errors but at patterns where mistakes consistently appear to be in the best interests of the physician. That may prompt some doctors to hand off their billing to an outside service, but Jillian Phillips, a certified coder who works in the OSMA Ombudsman Department, cautions members to be careful about the billing service they use.

That's because billing service companies are among the "hot targets" on the OIG's 1998 work plan. An article in the January 1998 issue of the *Journal of the American Health Information Management Association* says the OIG's review of services will "determine whether Medicare claims prepared and submitted by billing service companies are properly coded in accordance with the physician services provided to beneficiaries and whether the agreements between providers and billing service companies meet Medicare criteria. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians (which would increase their own percentage rate for collections)."

Finding reputable services

So how do you find a reputable billing service?

"Word of mouth is the best reference," says Phillips. "Contact colleagues who use billing services and ask

who they use, and whether or not they are pleased with the service."

You might also turn to the OSMA's Consulting Services Directory. Although the OSMA does not endorse any of the billing companies listed, it does provide you with a place to start asking questions.

Phillips says physicians need to thoroughly check the billing services they send their accounts to. "You need to be cautious," she warns, "because, ultimately, you are liable for the billing, no matter who actually does it."

What to look for

She recommends you take the following steps before hiring any billing service you are considering:

- **Ask for references.** "Ask for the names of five physicians who use their service, and give them a call," says Phillips. If the service can't provide you with at least five names, "Take that as a clue that this is either a very new business or one that not many others are using," says Phillips.

- **Check out the facility personally.** An increasing number of services these days are set up in homes by individuals who have not been trained in coding, says Phillips. A trip to the service's facility will tell you whether or not this is a company that has trained staff, and how that staff operates.

- **Determine if the service subcontract its work.** "There are some billing services that do not do the coding and/or billing themselves," says Phillips. Instead, these companies may subcontract with those home-based businesses stated above. You should know who will be doing the coding/billing before you sign a contract.

- **Ask how long the service has been in business.** Phillips says that more and more billing services are starting up each year, and while a brief length of

time in business isn't necessarily bad, inexperience is. "Make sure that the services you hire have certified coders on staff," she advises. "And that they know what they're doing."

- **Examine the service's credit and year-end reports.** These will help you determine whether or not the company is legitimate and has a business plan in place. If the service is unable to produce any of these reports, you may be dealing with a company that won't be around long enough to complete the work.

- **Make sure that confidentiality is respected.** "The records you send the service include patients' names, procedures and diagnosis codes," says Phillips. "You need to be certain that the service knows this information must be protected and has a system in place for that purpose."

You have a responsibility to these services as well. "Make certain you provide the billing codes," says Phillips. "Don't write out a diagnosis and expect the billing service to determine the code. It's unfair to expect the coder to arrive at the right code without the proper documentation and pertinent information."

Billing services can be of great help to physicians but keep in mind that these businesses, like any you deal with, need to be checked out before you contract with them. Following these steps should help. ■

Take Action

If you have questions about what you should look for in a billing service or would like information about coding, contact Jillian Phillips, MA, CCS-P, CPC, certified coder, 1-(800) 766-6762, Ext. 214.

Ask the legal department

Q: I have never reused instruments or other disposable items marked as "single use" by manufacturers because I believed the law prohibited such action. Recently, however, a colleague told me that the rules have been changed and that, if the item is properly disinfected or sterilized, it may be used again. I'd like to reuse some instruments in my practice to save money, but I'm afraid I'll lose my license. Do you know of any change in the law?

A.: The State Medical Board of Ohio voted last December to adopt rules amending the section of the Ohio Administrative Code (OAC 4731-17004(G)) that prohibits licensees from reusing "single use" items contaminated by blood or body fluids. The new rules now state that instruments and other reusable equipment used by licensees who perform or participate in invasive procedures shall be appropriately disinfected, sterilized and reused in accordance with current guidelines established by the Food and Drug Administration.

In addition, the reused item's physical characteristics and quality must not have been adversely affected, and the items must be capable of being reused safely and effectively for their intended use.

Keep in mind, however, that you may be potentially liable for adverse patient outcomes caused by single-use items. Make certain that you review the manufacturer's instructions and information about the single-use equipment before you reuse it, and be prepared to show that the device has been sterilized (an increasing number of companies now offer reprocessing and sterilizing of single-use items) and that the item is safe for its intended use. ■

OSMA Web site offers twice weekly updates

If you haven't visited the OSMA Web site recently, you've not only missed some important information, but you've missed the opportunity to voice your opinion on the BWC's HPP program and Stark II Rules. Members have been able to reach OSMA on the World Wide Web at www.osma.org since January.

The Web site is updated every Tuesday and Friday, and more often if needed. The site is the best way for members to get the latest information.

Some basic tips to help you find your way through the Web site are:

- **Main Menu:** After entering the OSMA home page, you'll find on subsequent pages, down the left-hand side, a main menu which shows the site's different sections. Just click on the section you want to visit. This main menu is available no matter where you move in the site, so you can easily switch from section to section.

- **Hot news page:** If you have time to read nothing else on the Web site, read the hot news page. This page will give you the latest headlines. Click on the headline you want to read to get to the news detail section which will give you the most up-to-date information. If there are additional links or contacts, this page will direct you to them.

- **News Roundup:** If it's been awhile since you've surfed the site, click on the News Roundup section to find the hot topics you missed during the last few weeks. However, this section is updated weekly too, so don't stay away too long.

E-mail collection

The OSMA is collecting e-mail addresses from members. If you have recently acquired an e-mail address or changed your e-mail address please notify: Karen Kirk or Brian Bruckelmyer at the OSMA either by fax (614) 486-3130, phone 1-(800) 766-6762, or e-mail osma@osma.org. If you e-mail us your address, please include your ME number so that we can link the address to the appropriate member. ■

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BWC holds HPP provider seminars

The Bureau of Workers' Compensation (BWC) has been holding a series of Health Partnership Program (HPP) training seminars for physicians and others since late April. The dates and places have been posted on OSMA's Web site, www.osma.org, and are also available on the BWC's Web site, www.ohiobwc.com.

For members who may not have access to the Web, the remaining program dates and locations are listed below.

The seminars are free and all meetings are scheduled from 8-11:30 a.m. An identical session, from 1-4:30 p.m., will be offered in Cincinnati and Cleveland. BWC staff members will answer questions and listen to your concerns. BWC Administrator/CEO James Conrad says the seminars are intended to be "an exchange of ideas on improving the bill paying process" as well as working out other wrinkles in the system.

To register for one of the programs listed below, you may call 1-(800) 466-6292 or e-mail: providertraining@ohiobwc.com.

BWC seminars will be held on the following dates in the following locations:

May 11 – Dayton, Convention Center

May 12 – Cincinnati, Sharonville Convention Center

May 13 – Toledo, SeaGate Convention Center

May 15 – Lima, Veterans' Civic & Memorial Center

May 19 – Zanesville, Muskingum County Welcome Center

May 21 – Cambridge, Prichard Laughlin Center

May 27 – Cleveland West, Clarion Hotel & Convention Center (Strongsville)

May 29 – Marietta, Lafayette Hotel

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How to choose a malpractice carrier

Before selecting a new malpractice carrier, there are five questions you should ask first. Your selection should be based on the answers you receive.

Insurance is supposed to "be there" when you need it, right? Unfortunately, as the recent liquidation of the PIE Mutual Insurance Company has shown, that's not always the case.

Physicians across Ohio scrambled to find alternative coverage when state regulators took control of PIE last year. The OSMA sent letters to member physicians urging those with PIE coverage to talk with their agents about switching to a new insurer, but picking a new insurance provider with confidence takes a bit of research, says Kim Willis, broker with Aon Risk Services, an international multi-service insurance brokerage and risk management consulting firm.

Factors known to contribute to in-

surance company failures include inadequate pricing, possibly coupled with inadequate loss reserves; rapid growth; asset misvaluation; catastrophes; excessive delays in settling claims; and mismanagement, according to the Risk Report.

Willis suggests five main points to look at when evaluating a potential insurer. A physician may choose to investigate prospective carriers alone or count on a trusted broker or agent to do the legwork.

1. How strong is the carrier's financial picture?

Check with Standard and Poor's, A.M. Best, or one of the other credit rating services. It's best to check with at least three services and to look for discrepancies or problem signs.

2. Does the carrier offer "claim made" or "occurrence" coverage?

The latter provides coverage regardless of when the claim is reported, as long as the incident occurred while the policy was in force. With "claim

made" coverage, the incident must have occurred and been reported to the carrier during the policy's period of coverage. This can be a problem for physicians in a field of practice with a "long tail." A pediatrician, for example, may be faced with a suit 20 years after an incident occurred. Some carriers offer retroactive coverage, or coverage that extends to cover those incurred but not yet reported claims. The availability and cost of such extra protection depends to an extent on the insurance market, Willis says. The insurance industry currently is in a soft market cycle which has kept premiums low with valuable extra protection, and brought more carriers into the marketplace.

3. What and who does the policy cover? What is excluded?

Physicians working with allied health professionals should assure that coverage extends to their staff members, including nurses, nurse practitioners, physician assistants and their corporations.

4. What is the insurance carrier's claim payment philosophy?

Certain carriers are known for paying claims more readily. However,

many physicians don't want a settlement on their record if they feel they did nothing wrong.

5. Will the carrier offer retired physicians a free "tail" coverage for incidents that occurred while the policy was in effect, but were not reported?

Another important question to ask the carrier is "If the physician is switching to a new carrier, is retroactive 'tail' coverage available?"

Before giving a malpractice carrier your business, make certain that the answers it gives you are ones that suit you and your practice. — Anna Rzewnicki

Take Action

Kimberly Willis of Aon Risk Services, Inc. has prepared a primer on malpractice insurance. For a copy of her report, "The Basics of Physician Professional Liability Coverage," contact the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 228 and ask for item #11-98. To contact Kimberly Willis directly, call (314) 854-0840.

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Insurer rating services

Check with at least three services before choosing a malpractice carrier. This will help you spot any discrepancies or problem areas with an insurance provider.

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For ratings:

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Correction

In the story "Which HMOs will stay?" in the April 1998 issue of *Ohio Medicine*, the HMO Paramount was listed incorrectly under Hamilton County, followed by a 42 percentage share of the marketplace. The HMO Health Power, with 27% of the marketplace, should have run in its place. Also, DayMed was listed with 1% share. It should have been listed with 11% share.

Also in "My Favorite Web site" the incorrect address was given for the American Medical Association's Web site. The correct address is www.ama-assn.org. *Ohio Medicine* regrets the errors. ■

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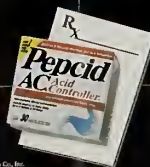
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Outcomes data needed to compete

Want to compete effectively in today's marketplace? Then you need to determine how your patients feel about the quality of care you provide them.

On May 16 the OSMA's Department of Continuing Education and Outcomes Research will present an educational meeting on the need for physicians to collect patient satisfaction data during OSMA's Annual Meeting at the Renaissance Cleveland Hotel.

The meeting will describe the evolving environment of data-driven health care, identify how different players in the health-care system use patient outcomes data, and explain how collecting and analyzing patient satisfaction and outcomes data can improve the services and quality of care that physicians provide.

The meeting will provide information about the patient-satisfaction/outcomes pilot project that the OSMA will launch in partnership with Health-care Research Systems (HRS). For more information, contact Janet Shaw, director of CME-Outcomes Research at 1-(800) 766-6762, Ext. 146. ■

Deadline nears for Workers' Comp program

Physicians interested in participating in the 1998 OSMA's Workers' Compensation Group Rating Program have until June 30 to apply. This year, more than 3,600 OSMA members participating in the program will reduce their annual Workers' Compensation premium payments by as much as 50% — saving a total of more than \$3.1 million.

To learn more about the plan, check the appropriate box on the response card in this issue of *Ohio Medicine*, and an application will be sent to you.

Note: Although the Ohio BWC has converted to a managed-care delivery system, the group rating for BWC premiums will continue to be in effect. ■

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Annual Meeting...

continued from page 1

mony at the reference committee hearing. "There are problems in organized medicine and the OSMA, but is this the solution?" asked OSMA Past-President Walter Reiling, MD, who spoke in opposition to delinkage. "We are under attack from government agencies, insurers and others, and we are discussing fragmenting ourselves even further. We need to stand united," he said. Another OSMA Past-President John A. Devany, MD, pointed out that medicine would lose its voice in the Legislature if medicine reduced its numbers further. And Tenth District delegate Louis J.R. Goorey, MD, pointed out that membership is down in all organizations, not just in medical associations, but that membership is important. "I don't know about you but when I buy a plane ticket, it doesn't matter to me whether the left wing or the right wing is more important. What's important is that the seat I paid for gets me where I'm going."

Delegates who favored delinkage pointed to the current "crisis of membership" that continues to decline at both the state and local level of organized medicine, as well as a need to revitalize the association. Delinkage opponents agreed that physicians need to better understand the value of organized medicine, but said that should be a problem undertaken in concert with local societies, and not independently. "Competition is good, but not in this situation," said one delegate who rose to speak in opposition to delinkage.

At the House, delegates retained all but the most controversial sections of Report A, including sections that called for Council to establish a more responsive and sensitive policy and issue resolutions process, focused task forces to deal with pressing issues, and increased mechanisms to create or enhance dialogue on matters of concern to OSMA members, including increased field representation. ■

Take Action

For a complete report of the actions taken on 1998 resolutions, contact the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 228 and ask for Item #16-98.

Bills, Laws & Rules

Rules revised for prescribing weight-loss drugs

Following several hours of testimony at a public hearing in April, the Ohio State Medical Board continues to work on revisions it has proposed for rules governing the use of appetite suppressants in the treatment of obesity.

Prior to the hearing, the OSMA reviewed and submitted comments on the revised regulations. Below are some of the board's proposed changes, followed by OSMA's comments.

- **Discontinue** or do not initiate treatment if the patient has a history of alcohol or drug abuse.

The OSMA believes the false or misleading statements about alcohol and drug use are not enough to justify immediate termination of treatment. If obesity is to be treated as a chronic disease, the side effects of the disease must be treated as well. The OSMA suggests that perhaps physicians should be required to document their justification for continuing treatment under these circumstances rather than to deny treatment to the patient entirely.

- **Set** the length of time for treatment at 12 weeks, and if a combination of drugs is prescribed, the total number of weeks for which they may be prescribed

is 12.

The OSMA questions the second part of this provision, and asks, in cases where a combination of drugs is prescribed, why each drug shouldn't be prescribed for 12 weeks. If a physician

Medical Board Report

finds one drug is not working and decides to switch to another drug that may help the patient, why cut that drug off before the patient has had the benefit of 12 weeks of treatment with the more effective medication?

- **Prohibit** initiation of a new treatment plan unless the patient has been off prescription drugs for weight loss for 18 months or more.

The OSMA has asked the board for its rationale in making this decision. Bariatric physicians oppose the board's attempt to regulate weight-loss drugs. In a letter to the editor published in Cleveland's *Plain Dealer*, James F.

Merker, executive director of the American Society of Bariatric Physicians, writes that the society and its Ohio members have urged the board to reconsider its thinking in adopting the regulations. Adopting the rules, says Merker, will make Ohio one of only four states that restrict the use of FDA-approved medications for the treatment of obesity.

Board members are considering the testimony and may amend its proposal regarding prescribing weight-loss drugs.

Of note...

Expert reviewers are needed to review records for the consideration of formal disciplinary action and to serve as expert witnesses. Physicians will be contracted by the board on a per case basis, and are reimbursed with an hourly wage.

Candidates should be board certified and spend at least 50% of their professional time in clinical practice.

For more information, contact Lisa Emrich, Standards Review and Intervention Supervisor, State Medical Board of Ohio, 77 South High St., 17th Floor, Columbus, OH 43266-0315. ■

Pages

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Sexual harassment in the workplace should be strangely discouraged says a joint statement from the OSMA and OHA: The Association for Hospitals and Health Systems.

10



Unplanned pregnancies can be prevented if physicians take time to talk to their patients about family planning options.

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Home-health care is a ripe area for Medicare fraud. Before certifying a patient for home-health care, be sure you know the criteria they must meet to qualify.

Your involvement can help shape 1998 election

Ohio elects a new governor and lieutenant governor this November but a number of Ohio legislative seats are also up for grabs.

It is vital to become a part of the political process if you want to have a voice in it – and at no time does this message become more important than during an election year. The Ohio State Medical Association offers two ways for members to become involved in politics. The Ohio Medical Political Action Committee (OMPAC) raises money to support candidates with views favorable to medicine and PLAN (the Physician Legislative Action Network) is the OSMA's grassroots program, mobilizing members to

support medicine directly through contact with their legislators. To join OMPAC or PLAN, contact Krista Bistline, Department of Legislation, 1-(800) 766-6762, Ext. 223 for more information or for application materials.

Whether or not you are a member of OMPAC or PLAN there is another way that you can help shape the 1998 elections. Consider hosting a fundraising event this summer for a candidate in your area who supports the views of medicine. Hosting or attending a colleague's fundraiser is an excellent way to meet the candidate, voice your concerns and show your support. The OSMA Department of Legislation can

help you plan these events.

Finally, don't forget to contact the OSMA prior to the elections and ask for OMPAC's recommendations for the legislative races. OMPAC's board gives careful consideration before selecting who it will support in each contest. By supporting OMPAC candidates you can be assured you are supporting a stronger voice for medicine.

Watch *Ohio Medicine* for more election news as the year continues. ■

PIE problems urge legislation

At the request of Gov. George V. Voinovich, the Ohio Department of Insurance has called for legislation that would require Ohio-based insurance companies to appoint at least one-third of their board members from people who are not affiliated with the companies. The request would affect all domestic life, property and casualty insurance companies in the state.

ODI thinks this type of legislation is necessary because of the board controversy that arose from the PIE Mutual Insurance Company and the internal committee structure of the former Blue Cross Blue Shield Mutual of Ohio.

ODI indicated that the legislation should allow for a mix of board members. The legislation would require board committees to be made up entirely of external members. ■

Will there be enough providers if CHIP expands?

The Ohio Child Health Insurance Plan (CHIP) Task Force continues to work to expand health-care coverage to uninsured children. Yet even if the task force finds a way to expand coverage, will there be enough health-care providers out there to care for them?



Richard Tuck, MD

A survey conducted in March by the Ohio Coalition of Primary Care Physicians casts some doubt as to whether or not there will be sufficient access to Medicaid providers in the future. According to the survey, Medicaid's low reimbursement rates (significantly less than Medicare) combined with new evidence of a decline in physician participation in Medicaid, may mean there are problems ahead for Ohio's children.

Specifically, the survey found that:

- Less than 30% of respondents accept new Medicaid patients (over 90% accept new non-Medicaid.)

- One in six physicians have reduced participation in Medicaid.
- Physicians who have left Medicaid indicate low reimbursement as the primary reason.
- Medicaid does not cover office overhead for 88% of responding physicians.

Richard Tuck, MD, a representative of the Ohio Chapter, American Academy of Pediatrics (one of the groups comprising the coalition), spoke to the CHIP Task Force in April about these concerns.

"The Physician Payment Review Commission's 1991 survey of Medicaid directors ranked low fees as the primary reason for low participation (in Medicaid) in over 30 states," says Dr. Tuck. Ohio's new market-driven approach to Medicaid is not addressing the problem, he continues. "This market-driven philosophy is of significant concern when one realizes that physicians who have been caring for those less fortunate children do so out of a moral and ethical commitment. In effect, they are subsidizing the Medicaid program by serving

these children at less than their cost."

In other words, the provider response to current Medicaid reimbursement is to choose between an ethical commitment to care for Medicaid patients and financial viability.

Dr. Tuck presented the Ohio CHIP Task Force with several reimbursement options:

1. A seamless reimbursement system equal to the private sector. This would eliminate a two-class system of care and assure access equal to the private sector.
2. Medicaid reimbursement that is, at least, equal to Medicare.
3. Primary care case management. In this system, a primary care physician who has committed himself or herself to be a "medical home" for a patient, would receive a per member per month case management fee. Dr. Tuck points out that this method has been studied in New York, and has been shown to significantly reduce emergency department utilization and hospitalizations, and thus saves the Medicaid system a number of dollars.
4. Specific increases in the percent of

RBRVS reimbursement, focused on CPT codes that reflect primary care and preventive services.

5. The creation of a non-Medicaid CHIP expansion, funded at the commercial rates with commercial reimbursement.

"The primary care physicians of Ohio are deeply committed to caring for the children of our state," says Dr. Tuck. "However, as the Medicaid program expands through CHIP to cover more children, inadequate reimbursement could significantly limit access to care provided by physicians. Without an adequate primary care provider base, quality care won't be possible. This access to care needs to be carefully measured and must be adequate for the Medicaid population. We urge the task force to present provider reimbursement as a critical issue as it develops its recommendations for CHIP expansion for the governor." ■

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Faulty arbitration clause means HMO can be sued

In on unanimous ruling, justices found the wording in CIGNA's arbitration provision was ambiguous.

The Ohio Supreme Court has ruled that a Ross County widower has the right to sue CIGNA Healthcare of Ohio, despite the presence of an arbitration clause in the policyholder's contract. The case, first reported in the February 1998 issue of *Ohio Medicine*, was brought to the court by a state employee who was covered by CIGNA. The employee had requested coverage for a new surgical treatment for liver cancer. The insurer considered the treatment experimental and refused to provide coverage. The policyholder and her husband sued to

force CIGNA to pay for the treatment. CIGNA appealed on the grounds that the health insurance contract calls for disputes to be settled by arbitration.

The policyholder died while the motion was pending, however, the suit was continued by her husband on his wife's behalf.

The appellate court ruled the policyholder's claim must be arbitrated, but her husband's claims could be settled in court. CIGNA appealed that decision to the Supreme Court.

In the unanimous ruling, justices found that the wording of CIGNA's arbitration provision was ambiguous. It's "not possible," the court says, "to determine what controversies are to be submitted to arbitration because it's not possible to determine what parties are to be in contention."

In other words, the Supreme Court's decision has only a limited application when it comes to addressing the issue of whether or not arbitration clauses in HMO contracts can prevent a policyholder from suing an HMO in court.

"The decision dealt specifically with the wording of CIGNA's contract," says Katrina English, JD, director, OSMA Division of Legal Affairs.

Nor did the court address any of the controversies between medicine and HMOs inherent in this case.

"Having addressed the issues before us on narrow grounds," wrote Justice Paul E. Pfeifer, "We need not determine whether it violated public policy

for an insurer to take two months to decide whether a woman, battling for her life against cancer, can have potentially life-saving surgery. That question, and others involving what constitutes a meaningful answer in a timely fashion will have to wait for another day."

Meanwhile, three bills that hold HMOs liable for the coverage decisions they make that result in harm to patients remain pending before a subcommittee of the Ohio House's Civil and Commercial Law Committee.

Ohio Medicine will continue to provide updates on the progress of these bills as they occur. ■

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If you or your associates meet the above qualifications, please forward a current CV to: AVATAR HEALTHCARE SERVICES, INC., P.O. Box 22645, Beachwood, OH 44122.

Quick news

"Any-willing-pharmacy" bill introduced...An "any-willing pharmacy" bill has been introduced in the Ohio House, allowing coverage for prescription drug services provided by any pharmacy that adheres to the policies established by health insurers and health insuring corporations. Rep. William Batchelder (R-Medina), who has introduced the bill (House Bill 720), says the legislation is necessary because the state is losing pharmaceutical business to other states and mail-order companies.

Amendment extends immunity for physicians...The law that provides immunity from civil lawsuits to physicians who operate or work at free clinics in Ohio or who treat indigent patients was due to expire in November. Thanks to the OSMA, the law may be extended another two years. The association was successful in adding an amendment to a similar bill, House Bill 612, which exempts dentists who voluntarily serve as dentists for athletic teams or who provide treatment to school athletes who need first aid or emergency care at school sporting events. HB 612 has been reported out of the Senate Judiciary Committee and should be on the floor of the Senate soon.

Attention to be drawn to Hepatitis C...It's official. Sen. Grace Drake's (R-Solon) bill designating the month of October as "Ohio Hepatitis C Awareness Month" has been signed into law and becomes effective July 22.

Joint policy on sexual harassment issued

The OSMA and OHA: The Association for Hospitals and Health Systems strongly disapprove of any form of sexual harassment in the workplace.

Earlier this year, *Archives of Internal Medicine* reported that more than one-third of female doctors were targets of sexual or gender-based harassment during 1993-1994. Younger doctors reported higher rates of harassment than their older colleagues, and medical schools were the most common site of harassment activities. Then, in April, an article appeared in the *Journal of the American Medical Association (JAMA)* in which medical residents say they have experienced mistreatment, including sexual harassment, during their internship.

The OSMA strongly disapproves of any form of sexual harassment in the workplace, and has recently issued a joint policy statement on the subject, together with OHA: The Association for Hospitals and Health Systems.

The policy defines sexual harass-

ment in the workplace as "unwelcome verbal or physical conduct of a sexual nature which can include pornographic pictures, e-mails, gestures and/or sexual language that creates or is intended to create a hostile work environment." Sexual harassment also may include conduct which indicates that employment, employment benefits or employment decisions are conditioned upon acquiescence in sexual activity.

Physician misconduct

Physician sexual misconduct and sexual harassment by physicians are not necessarily the same, however. Physician sexual misconduct, which may result in disciplinary action by the State Medical Board of Ohio, is behavior that exploits the physician-patient relationship in a sexual way. This behavior is nondiagnostic and nontherapeutic, may be verbal or physical and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual.

Physician-patient sexual miscon-

duct occurs when a physician uses his or her dominance over the patient to commit sexual acts, and physician misconduct can occur in all circumstances in which the physician, by virtue of his or her position, has dominance or "power" over another. These relationships can include: physician-nurse; physician-hospital staff; physician-students and residents; and physician-families of patients.

Sexual harassment

Sexual harassment, on the other hand, can occur in any of the above relationships when the physician makes unwelcome sexual advances, requests for sexual favors or verbal or physical activity through which submission to sexual advance is made an explicit or implicit condition of employment or future employment or work-related decisions. Sexual harassment may result in legal action against the physician and/or entity with which the physician is associated.

The OSMA and OHA recommend that every medical staff, hospital and

health system implement policies that declare such harassment unacceptable and that they strictly enforce these rules. ■

Take Action

The OSMA/OHA joint sexual harassment policy statement has been posted on the OSMA's Web site, www.osma.org. If you have missed the policy, or do not have access to the Web, you may obtain a copy of the full statement by contacting the OSMA reader response line and requesting Item #14-98. For further information on this subject, you may also refer to the AMA's ethical opinion 8.14: "Sexual Misconduct in the Practice of Medicine," as well as the article, "Sexual Misconduct: Accountability and Responsibility," published in the Fall 1996 issue of the State Medical Board of Ohio's publication *Your Report*.

Do You Know An Outstanding Young Physician?

If you know a physician who is an OSMA member, under the age of 40, and who has displayed outstanding service to his or her profession, community or to organized medicine, *Ohio Medicine* would like to hear from you. Please send in the name, address, and phone number of the physician you would like to nominate and briefly explain the reasons for nomination (services, activities, positions held). Deadline for nominations is Oct. 30, 1998.

Send your nomination to:
Ohio Medicine Editor
Young Physician Recognition
1500 Lake Shore Drive
Columbus, OH 43204-3891



Forum HEALTH

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Since 1972, Tod Children's Hospital has served as a regional referral center for six counties in Northeastern Ohio and Western Pennsylvania. The 97-bed children's hospital is affiliated with Northeastern Ohio Universities College of Medicine and supports accredited residency programs in Pediatrics and Medicine/Pediatrics.

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Robert A. Felner, MD, FAAP
Chairman and Medical Director
Tod Children's Hospital
500 Gypsy Lane
Youngstown, OH 44501
(330) 740-3908

The PHPPA Advantage

Physicians now have some "due process" rights

It used to be a managed-care organization (MCO) could drop you from its panel without giving any reason why. Now, thanks to the Physician-Health Plan Partnership Act (PHPPA), Ohio physicians are provided with some due process rights in holding onto their position with the MCO.

"This isn't 'due process' in the legal sense of the word," says OSMA Legislative Director Tim Maglione. "But it does afford physicians with some basic protections and gives them an opportunity to improve their performance, according to the plan's standards."

For example, let's say a plan has a concern about the high number of Caesarean sections you perform, well above the guidelines set by the MCO.

"Before it can terminate you, the MCO must first notify you of its concerns and give you an opportunity to correct your practice."

Before it can terminate you, the MCO must first notify you of its concerns and give you an opportunity to correct your practice. If you fail to comply and are then terminated you may appeal. For example, you may believe you have justifiable reasons for your high c-section rate. Maybe in your practice you see a number of high-risk patients. In that case, you may appeal your case to a provider panel. You will

be permitted to present them with all of your information and data. The panel then makes a recommendation based on all of the facts you've presented. That recommendation is approved, or not, by the medical director of the plan.

Will this provision render "termination without cause" clauses invalid?

"I think it can be argued that a plan will not be able to use these clauses anymore, unless the MCO has made a decision to downsize its panel," says Maglione. In cases of downsizing, a plan will not have to allow a physician to have a voice in his or her termination.

"There are some who believe this may be a loophole for MCOs, that they will use this as a reason for terminating physicians from panels," says Maglione. "But we have been assured by legislators that if plans begin to terminate physicians in this way, they will return to the law and clarify its intent."

The Physician-Health Plan Partnership Act passed last year, and was developed with the help of the Ohio State Medical Association and Kaiser Permanente. ■

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Tort reform diminishes earnings

When trial lawyers challenged the constitutionality of Ohio's tort-reform law in a suit filed with the state Supreme Court, Attorney General Betty Montgomery filed a motion to dismiss.

Where's the injury? she asked, pointing out that the suit anticipated harm when, in fact, no evidence could be presented that the tort law had actually injured any of the parties of the suit, nor any Ohioan.

The trial lawyers have crafted an argument in response to Attorney General Montgomery's motion and it focuses, not unexpectedly, on financial loss incurred by the Ohio Academy of Trial Lawyers and its members.

According to their filing, trial lawyers assert that, because of the tort-reform law, they "will suffer a diminution of their earnings," and substantial damages to their business. In fact, they argue, "a substantial number of members have chosen to abandon personal injury practice and not renew their membership in the academy" because of tort reform.

The trial lawyers' suit remains in the Supreme Court and the justices have asked for expanded arguments from both sides before they issue a decision. ■

Anthem's switches to single postal box

Effective May 1, Anthem Blue Cross and Blue Shield has established a single post office box for all incoming mail that is sent to the carrier here in Ohio. This does not include any electronic mail.

The new post office box replaces boxes 425, 700, 6009, and 6025, all located in Worthington. Anthem's new address is:

Anthem Blue Cross and
Blue Shield
PO Box 37180
Louisville, KY 40233-7180

Take Action

The Ohio Alliance for Civil Justice, co-chaired by OSMA Legislative Director Tim Maglione, continues to monitor all suits brought against the tort-reform law through its Court Watch program. If you would like more information about OACJ, the tort-reform law or the trial lawyers' suit, contact Tim Maglione, 1-(800) 766-6762, Ext. 220, e-mail: maglione@osmo.org

Dateline Ohio

OSU trains students in home health care

The Ohio State University College of Medicine and Public Health is one of 10 medical schools nationwide chosen to participate in the Hartford Foundation Program, "Expansion of Home Care into Academic Medicine." The program is intended to influence students' attitudes and practice approaches to the provision of home care.

Funded locally by the Columbus Medical Association Foundation (CMAF), the program may become a model for other schools.

Beginning this fall, all Ohio State fourth-year medical students will be required to participate in the program during month-long rotations involving in-home patient visits with professional home care providers. The requirement has applied to 80% of fourth-year Ohio State medical students since last September.

The grant funding began Nov. 1, 1997, allowing broader implementation of the home-care curriculum component already in place at Ohio State.

OSU requires rotation

Students choose among 29 rotation "selectives." Rotations involving home care may be combined with another rotation requirement—chronic care medicine. Of the 10 schools participating in the Hartford Foundation Program, Ohio State is the only one to require a rotation in chronic care medicine, according to Dr. Bonnie S. Kantor, director of the offices of geriatrics and gerontology at the Ohio State University Medical Center, and co-director of the program.

The amount of students' time spent in home-care settings varies by selective. For instance, within a palliative medicine and hospice care rotation,

students may spend up to 80% of their experience in home care settings.

However, in a physical medicine and rehabilitation service rotation, the in-home time commitment may be only two half-days during the month.

Students interact with patients of different age groups with a wide range of chronic and acute concerns, as well as with in-home caregivers. All students have geriatric experiences.

Focus is on medical, functional, environmental and caregiver assessments and interventions, such as end-of-life issues and pain management in the home. Courses and contracts emphasize patient maintenance of function and quality of life over time.

"House calls have been a traditional part of family practice, but uncommon in other specialties," says Edward T. Bope, MD, a CMAF board member and director of the family practice residency program at Riverside Methodist

Hospital.

Making house calls

"This program helps all medical students become more comfortable incorporating house calls into their practices and helps them appreciate the great resources and dedication caregiving family members have."

As hospital stays become shorter, home health care is taking a larger role in the care of patients, says Dr. Kantor. "Home health care has become a popular option for patients with acute illnesses who need health care but not necessarily the degree of medical attention they would get in a hospital."

"The overall goal of the program," she continues, "is to ensure that all graduating medical students understand the importance of home care and acquire the knowledge to help their patients make the best decisions for their particular needs." — Carol Larimer

HealthBridge brings info to Cincinnati physicians

Cincinnati is edging closer to an intranet system that will eventually link together physicians, hospitals and insurers in the tri-state area. Named "HealthBridge," the not-for-profit system will make it faster and more efficient for doctors to receive information about their patients—from medical records to coverage limitations.

Phase one of the system, linking one hospital and one payor with five physicians' offices is almost complete. Phase two brings into the network most of Cincinnati's health-care community.

Most physicians who have used the system find it an easy way to transfer

data, and through e-mail, exchange information about patients to other referrals.

Because HealthBridge is a private, intranet system, all information is secure and confidential.

Seven health-care sponsors have financed the system and subsidize, to a great extent, physicians' access to HealthBridge. The only cost to Cincinnati physicians is the price of a phone line and a personal computer.

Future plans call for HealthBridge to add links to the Centers for Disease Control, immunization databases and other health-care sites. ■

Perinatal foundation needs exec

The Ohio Perinatal Quality Foundation (OPQF) is seeking to hire an executive director. The OPQF is a voluntary statewide peer review organization with membership open to all providers of perinatal services in Ohio. The foundation is operated under the joint auspices of the Ohio State Medical Association and the OHA: The Association of Hospitals and Health Systems. The foundation's mission is to establish an ongoing structure and process to achieve high quality, universal access and cost-effective outcomes of perinatal services.

The executive director will be responsible for the management of the foundation, including operations, organizational management, external relations with OHA and the OSMA and external relations with state agencies and the public.

For more information about the position, contact Brent Mulgrew, OSMA executive director, 1-(800) 766-6762, e-mail: brentm@osma.org or David Engler, OHA, (614) 221-7614, e-mail: david@obanet.org. ■

Aggressive stance taken to control rabies

The Ohio Department of Health (ODH) has conducted a third baiting in an attempt to control the spread of raccoon rabies in northeast Ohio. The air baiting, conducted by the Ontario Ministry of Natural Resources, covered 1,540 square miles of Ashtabula, Trumbull, Columbiana, and Mahoning counties where repeated problems with rabies have been reported.

ODH Director William Ryan says the aggressive efforts to control spread of the rabies is especially important because of this year's mild winter.

So far this year, 14 cases have been reported. ■

Public health

Preventing unplanned pregnancies

By all measures, one of our main public health problems is our embarrassingly high rate of unplanned pregnancies, now estimated to be 57% of all pregnancies (85% for teens). This leads to over a million abortions each year. Women with unplanned pregnancies are more likely to:

- Divorce
- Drop out of school
- Deliver prematurely
- Abuse their babies
- Suffer depression and physical abuse
- Need financial assistance from the state
- Delay prenatal care and
- Expose their fetus to drugs

What you can do

There are steps that physicians can take to reduce the number of unplanned pregnancies. For example:

1. Be sensitive, clever and wise in assessing each woman's need for a family planning method.

If you're not particularly comfortable asking about sexual issues (and many—especially with teens), you could have patients complete a questionnaire or have your nurse ask, "Do you have a need for a family planning method these days?"

2. Lobby your Congressional representative to co-sponsor HR 2174, Equity in Prescription Insurance and Contraceptive coverage. This would require insurance plans which cover medications to also cover family planning methods.

3. Strongly encourage patients to take control of their health and future by using effective family planning methods. In order of decreasing effectiveness, these are:



There are a number of steps physicians can take to prevent unplanned pregnancies.

• **Vasectomy.** This is an easy office procedure followed by 48 hours of rest. Most studies prove no excess risk of prostate cancer unless the patient is less than 35 years old and/or has a family history of prostate cancer. Failure rate: 1/500 lifetime.

• **Tubal sterilization.** Almost always done, now, through a laparoscope. Involves at least three hours in an outpatient surgery center and one or two days off work. Can be done under general, regional or local anesthesia. Failure rate: 1/150 lifetime.

• **Paraguard IUD.** Lasts one year. Makes menses 30% heavier but extremely high satisfaction and continuance rates. Failure rate: 0.5% per year.

• **Progestasert IUD.** Lasts one year. Makes menses lighter. Failure rate: 3% per year.

• **DepoProvera.** 150 mg IM every 10-13 weeks. Great for teens who usually have compliance problems with pills and condoms. Great for women who don't like periods or have relative contraindications for estrogens. The continuance rate is only 70% because of the irregular bleeding in the first 2-6 months (warn her it will be impossible for her to have regular periods.) Although it eventually eliminates all bleeding (and PMS), patients find it makes them moody and the average weight gain is five pounds yearly. Failure rate: 0.5% per year.

• **Norplant SC capsules.** Lasts five years and takes only six minutes to in-

sert (10-20 minute to remove). Great for teens who don't like shots or the prospect of weight gain with Depo-Provera. Unfortunately, 85% have lots of spotting in the first year (can be managed with estrogen or oral contraceptives.) Continuance rate: 75%. Failure rate: 0.5% per year.

• **Oral contraceptives.** Convenient and only \$8/month for generics. Decreased: dysmenorrhea, blood loss, PMS, premenstrual headaches, benign breast disease, ovary cancer (by 40%), hirsutism and acne. Teens average two missed pills a month so failure rate ranges from 1-25% per year.

• **Progestrone-only minipill.** Good option for nursing mothers, smokers over 35 or those who get nausea or headaches on combination pills. Failure rate is: 3-20% per year.

• **Condoms.** Also prevents STD's. Main problem is imperfect compliance (which should be managed with emergency contraceptive pills.) Failure rate: 5-30% per year.

• **Diaphragm.** Difficult for many to insert easily and properly. Failure rate: 5-20% per year.

• **Emergency contraception.** Within 72 hours of unprotected intercourse, she takes two high-dose norgestrel pills and 12 hours later she takes another two (or two doses of four low-dose norgestrel or levonorgestrel pills.) Because 30% have bad nausea, patients should take an antiemetic one hour before each dose. Failure rate: 2%.

• **Spermicides.** Extremely easy to acquire and use but not particularly effective. Can be used with condoms to improve effectiveness. Good for married couples wanting an easy method for two to three months after a miscarriage. Failure rate: 20% per year.

The key to public health is shifting the focus to preventing problems instead of just "fighting fires." Please try to convince your patients to prevent unplanned pregnancies, and talk to your children as well. — Ed Miller, MD, is a member of the OSMa Public Health Committee

October 2, 1998

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Letters

Disciplining doctors

To the Editor:

In response to the article on the Ohio Board rank on disciplining physicians ("Ohio ranks tough on discipline" April 1998), I feel it is a sad day when the board uses a physician's illness to make headlines.

Chemical dependency is a disease, as is diabetes. When either is not controlled, the person may be impaired. What the board seems to ignore is that chemical dependency is treatable. Treatment does work.

Further, society has to pay hundreds of thousands of dollars to replace the physician instead of the physician paying to treat the disease. Society may be at increased risk because the board's action discourages physicians from seeking treatment.

It is my understanding that approximately one-quarter of physicians are at risk for chemical dependency. I feel it is in our patients' best interests that impaired physicians be treated for their disease, not disciplined. I feel a physician that has been humbled by a chronic disease will have more compassion, and the final result will be better health care for the patient.

Kenneth K. Kline, MD
Glen Dale, West Virginia

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OSMA News

Cincinnati Academy launches own computer training center

Hamilton County

Cincinnati-area physicians and their staff members will soon be able to bone up on the latest computer software at a new training center established just for them. It is being built in recently-vacated space at the Academy of Medicine of Cincinnati offices with financial support from several area hospital groups.

The idea for the training center grew out of discussions between the academy and hospital officials, says Russell Dean, executive director of the academy.

"Last summer, we had been doing some physician training on computer basics at the University of Cincinnati Medical School," he says. "These classes became so popular that we began to feel we were in the university's way and started to think of another way to do this."

Academy President Molly Katz, MD, discussed the successful training program with members of the Health Alliance and mentioned the need for another site. The Alliance also needed to prepare staff at member hospitals for a new computer system. At about the same time, the academy had relocated its telephone answering service, leaving a vacancy in a portion of its building.

County Medical Society News

Support for an academy-based computer training facility grew rapidly. Soon after discussions began, officials from one hospital called to volunteer financial support. By December, the academy wrote to the remaining hospitals in the area, and now has Cincinnati's four major hospital systems involved in the project, with discussion under way with several independent hospitals.

"We are putting together an advisory group," says Dean. The group will provide oversight for the center which will be administered by the academy. "We will provide the space, scheduling and maintenance," Dean adds.

The center will have about 12 to 14 computer work stations. Hospitals or physicians using the space will provide the students, as well as their own instructors and materials. A fee structure to cover expenses for use of the training center is under development, says Dean.

The academy is currently soliciting

bids for the project, and hopes to have the computer training center open for use by August at the latest.

For more information about this project, contact Russell Dean at the Academy of Medicine of Cincinnati, (513) 421-7010. — Anna Rzewnicki

Franklin County

The Columbus Medical Association and Foundation have changed administrative leadership.

Executive Director Ron L. Fitzwater resigned in April to pursue other career interests.

Associate Executive Director Tracy Schieffele and Director of Community Relations Diane McDaniel have been named to the position of co-interim executive directors for the Columbus Medical Association. CMA and CMA Foundation Director of Finance Laurie Gray has been named interim executive director for the foundation.

Trumbull County

Trumbull County Medical Society recently sponsored a managed-care open forum where important survey data was discussed. The data was derived from patient questionnaires.

Here's what some of the patients had to say: 52% felt they are receiving lower quality care compared to 3 years ago; 65% said their health insurance premiums have not decreased; 91% said it is not right for a doctor to receive financial bonuses for not referring patients to specialists or not referring certain tests; 54% felt that the added paperwork has decreased the efficiency of doctors' office staffs; 63% of managed-care patients felt that treatment withheld from them because of insurance plan coverage had an adverse outcome on their health; 62% felt the quality of care at their local hospital had decreased in the last 3 years. ■

Colleagues

MARK T. BERGMANN, MD, Cincinnati Eye Care Associates of Cincinnati Inc., has been appointed secretary/treasurer of the Cincinnati Society of Ophthalmology for 1998.

JULIA CORCORAN, MD, Cincinnati, began volunteer missions five years ago in Guatemala, with a program called "Healing the Children." She recently spent a week doing general surgery.

RICHARD FRATIENNE, MD, Cleveland, was reappointed to a term ending Nov. 12, 2000 as a representative of the Ohio Chapter of the American College of Surgeons. Dr. Fratiene is with Metro-Health Medical Center.

MARK E. GROSINGER, MD, Cincinnati, was elected to the office of president of the Ohio Osteopathic Eye, Ear, Nose and Throat Society. Dr. Grosinger is the senior partner with Montgomery Ear, Nose and Throat Clinic, Inc.

YOUSSEF HAZIMAH, MD, Toledo, was honored as the hospital's "Physician of the Year." The award recognizes a physician who exemplifies loyalty, quality and service to the medical profession.

DEAN J. KERELAKES, MD, Cincinnati, has been honored with the 1998 Health Care Heroes Award for administering innovative cardiac care and research in Greater Cincinnati. He is a cardiologist at the Ohio Heart Health Center. Dr. Kerelakes is medical director of the Carl & Edyth Lindner Center for Clinical Cardiovascular Research at Christ Hospital. ■

AMA-OMSS to meet June 11-15

Members of the AMA's Organized Medical Staff Section (OMSS) will meet in Chicago June 11-15 at the Sheraton Chicago Hotel and Towers for the 31st AMA-OMSS Assembly Meeting.

Topics to be discussed are:

- Managing physician organizations
- Negotiating and resolving conflicts
- Capitation

- Unionizing
- PSOs and Medicare risk contracting
- E&M Documentation guidelines

AMA-OMSS members will have a chance to participate in advocacy, policy-making and networking activities. For more information, call the Department of Organized Medical Staff Services at 1-(800) 621-8335. ■

OSMA's 1998 Annual Meeting



(Above) Jack Summers, MD, Akron, reviews the work of the Task Force 2030 with an interested delegate. Dr. Summers was chair of the task force.



(At right) Daniel Ciomens, MD, Seventh District Councilor, left, and Walter E. Bensley, III, MD, Third District Councilor, share a lighter moment during the resolution committee hearings.



Su-Pa Kong, MD, Toledo, told delegates during his presidential address that his grandson has a brighter health-care future thanks to actions OSMA took this year.

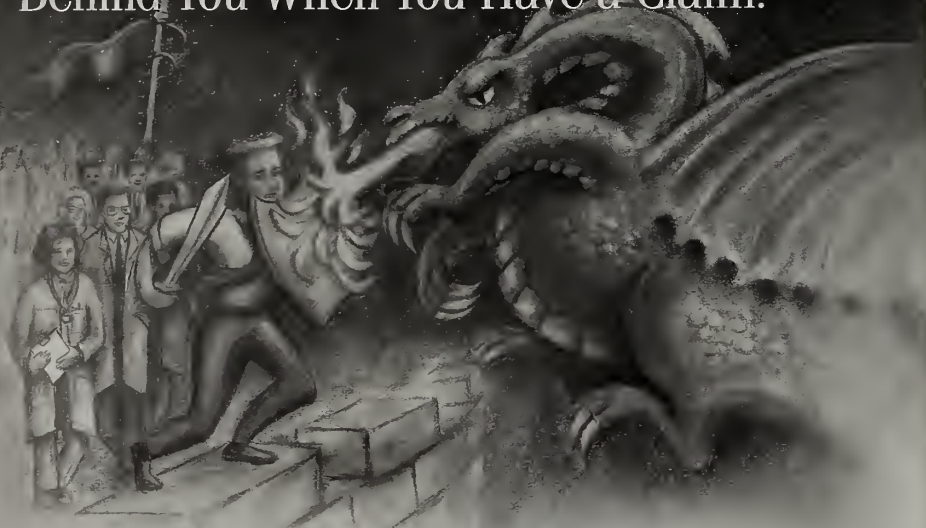


The handout table is a popular stop on the way to the Final Session of the House of Delegates. Here delegates pick up reports from the four resolutions committees.



At the President's Reception, past president John F. Kroner, MD, left, Su-Pa Kong, MD, immediate past-president, and Lance A. Talmage, MD, new OSMA president pose with friends - Hawkeye Pierce (actor Alan Alda), right, and the cardboard figure on the left is none other than our new president in combat gear. The M*A*S*H theme prevailed with ice-sculptured jeeps, helmets and grenades used for vases, and bartenders dressed in scrubs.

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Teamwork, realism, action

Editor's note: *The following article has been excerpted from the speech given by incoming OSMA President Lance Talmage, MD, at this year's Annual Meeting in Cleveland.*

I've always loved the game of football and the military. For me, they're the ultimate examples of active and aggressive teamwork. Without each member of the team giving full, unselfish effort, the whole plan breaks down.

I see myself as the quarterback or field commander. I know the strengths and weaknesses of the team members. The House of Delegates is the coaching staff which makes up the strategy. The OSMA Alliance, residents, students, etc. are the homefront support.



Lance Talmage, MD

As a team, we must recognize reality. In a game, it's necessary to know

where we are vulnerable and where we will have to sustain losses in order to achieve final victory. A strategic retreat has often gained us valuable time and allies.

Our opponents must learn to recognize our line in the sand. We have no credibility if we are not advocates for quality patient care. I think it's realistic to stand up for the right of physicians to be fairly compensated.

Another reality is our need to step up to educate and discipline if necessary. Those of our team who degrade and diminish the rest of us. And a final reality — we must come to grips with our treatment of patients. We have already lost many patients to unproven alternate practitioners. Organized medicine is the only way we can stand together to constructively critique each other. We must use our collective talent and commitment to make each of us better than we could be on our own.

Let's dedicate ourselves to action. The game moves too fast for us to

President's Perspectives

ignore the electronic weapons we must use. We have to have data and communicate effectively before a crisis. Our opponents are too well-organized and committed to their agenda for us to wait and hope for a break. A winning team creates its own breaks. Regardless of how we decide to modify or keep our organizational structure, we have to be more proactive and quicker to react when needed.

As president I will start a program to involve our patients in the legislative and regulatory process. They must be made aware of what is happening to their right to quality health care provided by a quality physician — a physician not overburdened with meaningless hassles and limits on good judgment.

We must actively solicit allies for each legislative and judicial battle, choosing just the right partner for the right battle. We may have to delay action on some dividing issues, but we must remain consistent in our long-term goals.

We must also answer the roll call for OMPAC. Our team needs to proactively enlist judges and lawmakers who will listen to medicine's voice.

I look forward to a year of teamwork with some of the best comrades in arms anyone could hope for. We must grasp and accept the realities of our struggle so that we can all be more effective. Take a positive step to preserve quality medicine, and the dedicated physicians who practice it, by recruiting your colleagues to join us in our fight for quality health care. We must have the talent and numbers if we're to win the battle.

Thank you for giving me a year of challenge as the captain of our team. ■

ROSARIO BELLO MD, California, Faculty of Medicine & Surgery University of Santo Thomas, Manila, Philippines, 1963; age 57; died March 11, 1998.

JOHN R. DONOHOO MD, Georgetown, Ohio, University of Cincinnati College of Medicine, Cincinnati, 1950; age 77; died March 8, 1998.

LLOYD L. DOWELL MD, Massillon, Ohio State University College of Medicine, Columbus, OH, 1935; age 86; died March 3, 1998.

HARRY FELSON MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1932; age 91; died March 9, 1998.

JOHN S. GOLDCAMP MD, Arizona, Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1934; age 89; died Feb. 17, 1998.

NICHOLAS GRAHAM MD, Florida, Faculty of Medicine, National University of Athens, Greece, 1932; age 90; died Feb. 28, 1998.

WILLIAM WOLF HERMAN MD, West Newton, Washington University School of Medicine, St. Louis, 1933; age 87; died March 4, 1998.

JAMES ALLEN PATRICK MD, Hubbard, University of Louisville School of Medicine, Louisville, KY, 1943; age 81; died March 17, 1987.

Obituaries

LEROY A. RODGERS MD, Toledo, Temple University School of Medicine, Philadelphia, 1966; age 61; died March 3, 1998.

REYNOLD A. TANK MD, Oregon, St. Louis University School of Medicine, St. Louis, 1926; age 97; died March 17, 1998.

NICHOLAS DEWEY WING MD, Copley, Albany Medical College of Union University, Albany, NY, 1962; age 61; died March 3, 1998.

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Practice Tips

Fraud-proofing your practice

Know criteria before certifying patients for home-health care

In March, the six-month moratorium the federal government had issued in an effort to stem new home-health care services from entering the Medicare program, expired. Consequently, you may be seeing a fresh influx of these agencies locating in your area, turning to you for referrals.

Before turning your patients over to a home-health agency, however, beware.

The 1998 edition of *Medicare Fraud and Abuse*, by Timothy S. Jost and Sharon Davies, explains why physicians should be wary of home-health services: "It would be difficult to design a program more vulnerable to fraud than the Medicare home-health program."

The warning, however, is nothing new. As early as January 1997, Warren internist Gary R. Gibson, MD, was alerting OSMa members to the need to reform the home care industry.

"The potential for abuse actually began about eight years ago," says Dr. Gibson. "Medicare began to pay generously for skilled home care visits by nurses, occupational therapists, physical therapists, social workers and other allied health-care providers," he says. "At the same time, the U.S. Congress prohibited physicians from participation in home-health care except for ordering the services. This effectively eliminated the physician from any role in the provision or oversight of home-health care."

In the meantime, Medicare payments for home-health care skyrocketed, and with increased usage came increased reports of abuse. In 1995, the Office of the Inspector General (OIG) had published several special fraud alerts concerning fraud and abuse in the home-health industry, and, by September 1997, the federal government had grown so concerned about home-health care fraud that it increased the number of claims

audited from 200,000 to 250,000 – and imposed the six-month moratorium on the entry of new home-health agencies into the Medicare program.

Since home-health agencies are primarily the target of these audits and alerts, why should you be concerned? For the simple reason it's your name on the bottom signature line of a Medicare certification form and that, ultimately, makes you the first line of defense against abuse by home-health agencies.

"Home-health agencies depend on physicians to certify the need for their services," says Nancy Gillette, JD, OSMa legal counsel.

And that means you had better have a clear understanding of who does and doesn't qualify for home-health care.

Medicare patients must meet certain criteria in order to be eligible for home-health services. The patient must be:

- **Homebound.** That's not easy to define, but Medicare says the patient doesn't necessarily have to be bedridden to qualify under the homebound criteria. However, they should be unable to leave the home other than for short, infrequent periods of time, for example, a walk around the block.

- **Under a physician's care.** If you have signed the certification form, the patient is your responsibility, no matter how frequently or infrequently visits are made.

- **Need skilled nursing services** intermittently, or other services such as physical or speech therapy.

If these criteria are not met by the patient, then he or she should not be certified for home-health care services, no matter how much pressure may be exerted by patients, patient family members or the home care agency itself.

"If the patient doesn't qualify accord-

ing to the criteria established by HCFA (Health Care Financing Administration), don't sign the certification form," says Gillette. Realize that sometimes the answer to patients must be "no."

Dr. Gibson has worked out a practical approach for working with the approximately 10 home-health agencies in his area. His approach not only precludes the appearance of fraud, but also assures the best quality of care for his patients.

"We've selected two agencies that have demonstrated the greatest quality of service at competitive costs, and arranged to have a case manager from each agency meet us at our office once a month. At that time, we review the status of the patients receiving home care and plan the next month, including consideration of whether home-health care will be needed any longer," he says.

Certifying physicians are expected by HCFA to complete a care plan and to recertify their home-health patients every 62 days, so Dr. Gibson's plan is a good one to put into place in your own practice.

"Virtually all of our new referrals and several transfers of existing patients with other services have gone to these two agencies," says Dr. Gibson.

He urges physicians to work with selected home-health care agencies in their areas.

"At least write the agencies and ask them to send you invoices for care they render to your patients," Dr. Gibson adds. "Before authorizing these services, it's important to have access to reports on specific services and their costs."

Finally, it's wise for physicians to have no business arrangements with home-health agencies, and that includes any remuneration to physicians for certifications or for referrals of home-health care beneficiaries. ■

Ohio implements home care program

Beginning July 1, the Ohio Department of Human Services (ODHS) will implement changes in the delivery of Medicaid home care services.

The new Ohio Home Care program will consist of three benefit packages:

- **Core** is designed to meet basic home care needs of individuals who need up to 14 hours of nursing and/or daily living services per week.

- **Core Plus** meets the home care needs of consumers who require more than 14 hours of nursing/daily living services per week.

- **Waiver** is structured to meet the home care needs of those whose medical condition and/or functional abilities would otherwise require them to live in a nursing home or other type of institution.

With each of the packages, there will be increased emphasis placed on the patients and their families, who are viewed as members of a team, responsible for the patient's care. Several new patient options will allow consumers to have greater flexibility in directing their care and selecting providers.

The ODHS will monitor compliance with the requirements for the Ohio Home Care Program through a quality assurance program, including outcome-based consumer interviews, consumer satisfaction surveys, contractor and provider site visits and reviews of consumer, contractor and provider records.

Educational sessions about the new program, including provider billing training, were held throughout May by the ODHS and were featured on the OSMa Web site, www.osma.org. ■

BWC issues report card rating MCOs

How are the managed-care organizations (MCOs) certified by the Ohio Bureau of Workers' Compensation (BWC) performing?

The BWC recently compiled and released an "MCO Report Card" for measuring the performance of those plans that participate in the Health Partnership Program, a managed-care initiative introduced last March.

According to the BWC, the report card, completed by employers and injured workers this past March, is designed to measure components that contribute to the quality of health-care services received by their employees. Factors that are rated include the MCO's timeliness of service, its overall employer and injured worker satisfaction and its return-to-work ratio.

"The OSMA's BWC Task Force has asked for an opportunity to provide physician input as well on these report cards," says Nancy Gillette, JD, OSMA legal counsel. So far, that request has not been granted by the BWC, although the bureau's director James Conrad wrote to the OSMA that the report card is still under development and that physician input regarding the managed-care plans participating in HPP may be considered in the future.

Results from the report card are intended to provide employers with information they need to make informed decisions during the HPP's annual open enrollment period. At that time (April 1 through May 29), employers may elect to stay with their current MCO or change to another plan. ■

Take Action

If you would like a copy of the MCO Report Card contact the Ohio Medicine reader response line, 1-(800) 766-6762, Ext. 228. Ask for Item #15-98.

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Walter Wielkiewicz, MD
www.sportingnews.com

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"Use of the site is free, unlike many other sports sites. However, I still subscribe to the monthly magazine, relying on the site primarily for scores and the magazine for analysis.

"The site was just recognized by the American Society of Magazine Editors as the best on-line magazine, for 'most effectively serving its intended audience and reflecting an outstanding level of interactivity, journalistic integrity and service.'"

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The *Sporting News* brings you just about everything you'd want from a sports site except the hot dog and beer. In addition to providing current scores and sports analyses of your choice, other pages allow you to be a fantasy commissioner, manager or owner; and other delivers great historical sports events and photographs. Live on-line "chats" are scheduled with athletes and irreverent commentator Fly gives you the buzz from behind the scenes.

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"The Nature of Championship Living"

continued on page 22

Contract issues

Ads and promotions: Value of your name

Managed care is a competitive business, and managed-care organizations (MCOs) aren't hesitant to produce advertising and/or promotional materials that tout their plan to potential employers and enrollees.

Some managed-care contracts may give the MCOs the right to use your name and other information in advertising and/or promotional materials without allowing you an opportunity to review the material first.

Why should you bother with something as inconsequential as an ad or marketing brochure? Two reasons:

1.) **Potential liability.** Broad statements, such as "We provide the best possible care" could be used against you in a malpractice trial as such statements raise the standard of care you're expected to provide patients.

2.) **Potential for discipline.** The State Medical Board of Ohio may consider some promotional material to be false representation or a promise you cannot deliver, and may discipline you as a result.

What about a listing in a physician directory? You may not have to worry about potential litigation or discipline in such cases but keep the following points in mind if you do agree to a listing:

- How you're listed. If you're a

primary care physician, you should be listed that way so that patients, new to the program, have an opportunity to select you when they enroll. If you're a specialist, you should be listed so that primary care physicians know who you are and that you are available for referrals.

- **Ask about updates.** Ask how often the directory will be published or updated. If the directory is not updated on a regular basis, and you move your practice or join another group, you may find that you receive no additional patients from the plan.

In all cases, remember that printing errors and informational mistakes occur, so it might be wise to stipulate in your contract that your prior, written consent for the use of your name, practice name, etc. be obtained before it is placed in any advertisement, promotional material or directory. ■

Take Action

The OSMA Division of Legal Affairs offers members a contract review service. For more information about this service, contact Kote Hunter, 1-(800) 766-6762, Ext. 129.

File check

A quick check through OSMA's files of contract analyses shows that the marketing/directory section in most contracts need clarification. A number of managed-care plans operating in Ohio do publish physician directories but most contracts don't state:

- how soon a physician will be listed after joining the plan;



- tell how frequently the directory will be published;
- state whether or not the physician may review the material prior to publishing.

Physicians are urged to have these points clarified before signing the contract.

Ask the legal department

Q. I currently care for a child in my practice whose parents have just divorced. The mother has custody but the father wants the same decision-making responsibility when it comes to his child's health. Recently, the mother agreed to an outpatient surgical procedure that I recommended for the child, and arrangements were made. The day of the surgery, however, the father called the hospital and canceled the procedure, saying he had not seen his child's records and until he did he would not agree to the surgery. Does he have the right to view his child's records and make medical decisions if he is the noncustodial parent?

A. This is a difficult question to answer because every divorce is different. It's up to you, however, to determine which parent is the decision-maker and what rights the other parent has when making medical decisions on behalf of the child.

If the mother is the custodial parent, then she would have the primary responsibility for the child and would act as the decision-maker. Yet under the Ohio Revised Code section 3109.051, the noncustodial parent is also given certain rights, including the same legal right as the custodial parent to access any of the child's records.

The only exception is if a court determines it would not be in the best interest of the child for the noncustodial parent to have unlimited access to the child's records. If that were to be the case, the court would issue an order specifying the terms and conditions under which the noncustodial parent would have access to the records. Without such an order, however, you are obligated to share the child's records with the father.

Failure to do so, incidentally, might find you in contempt of court, and you might be ordered to pay a penalty, court costs for the hearing on the issue of contempt, and/or the attorney's fees of the adversely affected party.

In summary, clarify what each parent's role is regarding the child's medical care, and allow both parents access to the child's medical records unless you are presented with a court order stating otherwise. ■

Take Action

If you have a legal question you would like answered, please send it to **Ohio Medicine**, OSMA, 1500 Lake Shore Drive, Columbus, OH 43204-3824, e-mail: ohiomd@osma.org

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Deadline nears for Workers' Comp

Physicians interested in participating in the 1998 OSMA's Workers' Compensation Group Rating Program have until June 30 to apply. More than 3,600 OSMA members participating in the program will reduce their premium payments by as much as 50%.

To learn more about the plan, check the box on the response card in this issue of *Ohio Medicine*, and an application will be sent to you.

Note: Although the Ohio BWC has converted to a managed-care delivery system, the group rating for BWC premiums will continue to be in effect. ■

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My favorite Web site...

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tion, since it is the most complete and authoritative source on regulatory matters affecting our profession. The "Hot News" button quickly shows me what's new and critical and the other sections, such as "Legislation," give me executive summaries. If I really want more details, to write a response to a bill, for instance, I can call or e-mail OSMa staff specialists."

What to look for:

The OSMa's Web site has been online since January. Begin with the "Hot News" page, which includes a "Round-up" option. This option provides you with former "hot news" topics so you can keep up-to-date on critical issues, even if you haven't visited the site for awhile. The "Hot News" page also updates you on upcoming OSMa meetings, seminars, etc. through the "OSMa Calendar of Events" option. Check out the membership information section for OSMa services, benefits, information on OSMa sections (i.e. Group Practice, Alliance, Organized Medical Staff) as well as brochures and other items to order from the OSMa store.

New to the site is a listing of the 71 CME sponsors, accredited by the OSMa. You'll find that list under the CME section, which also allows you to locate various continuing medical education activities by location, date and/or activity.

The bulletin board allows you an opportunity to communicate with your colleagues by posing (or answering) a question, and links connect you to other helpful Web sites.

The site is updated twice weekly, and your comments and suggestions are always welcome. Contact Karen Kirk, 1-(800) 766-6762, Ext. 221, e-mail: ohiodmed@osmo.org — Carol Larimer

Take Action

Do you have a favorite Web site you would like to share with *Ohio Medicine* readers? Contact Koren Edwards, editor, 1-(800) 766-6762, Ext. 232, e-mail: ohiodmed@osmo.org

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Cincy OBs walk away from Aetna

Aetna/U.S. Healthcare's latest contract terms proved to be the last straw for a group of at least 20 Cincinnati-area physicians who decided to terminate their relationship with the insurer.

The physicians, all obstetricians-gynecologists, complained about Aetna's "all-or-nothing" contract — forcing physicians to participate in all Aetna products — as well as the issue of who controls patient care. They also expressed concerns unique to their specialty.

The OSMA and the American Medical Association have been actively involved on this issue and notified Aetna earlier this year of physician concerns over the insurer's contract. Aetna, however, has chosen to keep its contract intact despite physician complaints.

A meeting, scheduled this spring between the OSMA, the Cleveland Academy of Medicine and Aetna to discuss the matter further was canceled by the insurer. Aetna explained it does not negotiate with trade groups, only member doctors, and cited antitrust laws.

The step taken by the Cincinnati ob-gyns comes at a price. Aetna provides managed care for 80,000 Greater Cincinnatians and 300,000 in Southwest Ohio, Northern Kentucky and Southeast Indiana. The insurer, though reportedly troubled by the walkout, says it still offers more than 240 ob-gyns to Cincinnati patients.

Yet, according to news reports, those physicians may not be far behind their disgruntled colleagues. ■

Ohio Medicine

A Publication of the Ohio State Medical Association

OSMA moves to new building

The OSMA is now operating from a new address. Association staff members moved last month from leased Columbus offices to a new building located in Hilliard, a northwest suburb of Columbus. The building is owned by the OSMA.

By now, you should have received information about the move, as well as directions. If you haven't received the material, or have misplaced it, contact the *Ohio Medicine* reader response line, 1-(800)766-6762, Ext. 6580 and ask for Item #19-98.

The building is 37,000 square feet, 10,000 of which is dedicated to meeting space. This will bring more of OSMA meetings and activities back in-house since there will now be space to accommodate large groups. There are conference rooms available, as well as board rooms for larger meetings. The largest board room seats 120 people classroom-style and 230 theater-style. In addition, OSMA members, on written request, may rent this meeting space for health-care related functions for a small fee. This is a benefit of your membership. Requests should be forwarded to Joe Moore, facilities manager, at the address below.

The OSMA's new address is 3401 Mill Run Drive, Hilliard, Ohio 43026. The new phone number is: (614) 527-OSMA



OSMA moves to new building. The OSMA is now operating from a new address in Hilliard, Ohio. The new space, owned by the OSMA, will bring more meetings in-house since there is more space to accommodate large groups.

(6762) and the OSMA's new fax number is: (614) 527-6763. The OSMA has also retained its toll-free telephone number, 1-(800) 766-OSMA (6762). ■

How to prepare for the new E&M Guidelines

"Like night and day." That's how OSMA's certified coding specialist Jillian Phillips, MA, CCS-P, CPC describes the before-and-after case of one member who attended two of the informal presentations she has given this past spring on the new E&M documentation guidelines.

"He attended a presentation I gave at his county medical society and one for his specialty society," says Phillips. "He had asked me to check over his records after I gave one of these presentations because he knew he needed help. After the second presentation, I looked over his records and the difference was phenomenal. He was in a much better position to be reimbursed appropriately for his services."

This fall, all OSMA members can

turn their own documentation around by attending one of the half-day presentations which the association will offer around the state. These presentations are an OSMA member benefit. Nonmembers who wish to attend will be put on a waiting list, says Phillips.

Here's what you will learn from these meetings:

- What's expected in the actual,

physical medical record.

- What's expected with regard to
continued on page 3

For an update on the status of the guidelines and what the OSMA and AMA are doing to make them more physician-friendly see the President's Perspectives page 15.



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E&M...

continued from page 1

E&M documentation requirements for a particular level of service.

- How to recognize the proper way to use E&M services in each CPT coding section, as well as the CPT modifiers.

- How "medical necessity" fits into the picture.

CME credits will be available for physicians and CEU credits for CCS-P and CPC coding certifications.

At present, implementation of the 1997 E&M documentation guidelines have been placed on hold and the guidelines themselves, thanks to the efforts of organized medicine, are being revised to make them more "user-friendly."

While HCFA has delayed implementing any new E&M guidelines, documentation of a history, exam and medical decision-making are still required, using the old 1994 guidelines or the July 1997 format. Revised guidelines will be implemented at some point in the future, says Phillips. "It's to the physician's benefit to learn how to properly document services now." ■

Take Action

For more information about the E&M documentation seminars, contact Cathy Sonnholler, OSMA Ombudsman Services department, 1-(800) 766-6762, Ext. 6759.

The OSMA is also offering its popular billing seminars, beginning in August. For more information see story on page 17.

Bills, Laws & Rules

HBs 641, 677, 685

Is managed-care accountability dead?

Is the managed-care accountability issue dead, now that the House has placed all three bills (House Bills 641, 677 and 685) making HMOs accountable for the health-care decisions they make, into one study committee?

The answer is yes – and no.

Don't look for legislators to handle this issue this year. It's an election year and not much business, if any, is expected until after the November elections and, in fact, until the first of next year. Even then, however, the bills face a tough road to passage. Rep. Dale Van Vyven (R-Sharonville), chair of the House Health Committee spoke of his opposition to the managed-care accountability measures at a recent health-care conference in Columbus.

"These three bills, if enacted, would create more harm than good," he says.

Managed-care organizations (MCOs) have already warned legislators that, if House Bills 641, 677 and 685 pass, then MCOs will force more restrictions on doctors. "Physicians, themselves, are divided on this issue," says Rep. Van Vyven. "Some doctors see managed-care accountability as a

source of relief; others see it as contributing to higher malpractice costs."

One lawyer, who testified recently before the Legislature, cautioned lawmakers about passing legislation that could "open the floodgates of liability lawsuits," threatening the new tort-reform law.

Rep. Van Vyven acknowledges the tension that exists between providers and managed-care companies, but says once the Physician-Health Plan Partnership Act is implemented (in October), he believes much of this tension will be reduced.

"The effects of this far-reaching legislation have yet to be seen," he says, and makes it clear that he is one legislator who wants to see how the PHPPA will work at bringing managed care and physicians together before he considers further managed-care regulation.

The OSMA is sensitive to its members' frustrations in dealing with managed care. For that reason, the association began meeting with employer groups and insurance companies this summer in an effort to negotiate a solution that all parties can agree to, yet

still addresses physicians' concerns.

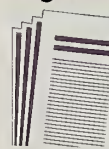
"We are trying to be sensitive to the concerns of these groups while at the same time, using this forum as a way to discuss the accountability issue as well as other managed-care related topics," says Tim Maglione, director of OSMA's Department of Legislation.

"By keeping discussions on this level, however, we hope to be able to move forward on the issue of managed-care accountability as well as other managed-care concerns. That way, when the Legislature is ready to pick up the issue again in January, we hope we will have made some progress on behalf of Ohio's physicians." ■

Sponsors: HB 641 – Rep. Betty Sutton (R-Barberton); HB 677 – Reps. Randall Gardner (R-Bowling Green) and Pat Tiberi (R-Columbus); HB 685 – Rep. Jeff Jacobson (R-Dayton).

OSMA position: The OSMA supports all three proposals but believes HB 677 is the most viable and balanced of the accountability measures.

Pages



7

The use of laser is growing and the State Medical Board of Ohio is now studying the issue of who is authorized to use them. The board has learned that 30 states currently regulate the use of these instruments.

14

OSMA members will have a greater voice in their association as a result of the work of the Task Force 2000. Focused task forces will help increase member involvement and keep members in touch.



16

The Ohio delegation to the AMA just became more effective. A resolution passed at this year's meeting will enable physicians' issues to be heard on the national level in a more timely fashion.

19



Anthem will trim Medicare HMO service in Ohio beginning Jan. 1, 1999. About 20,000 of Anthem's more than 63,000 Medicare HMO members will be affected.

APNs tell legislators why they should prescribe

Advanced practice nurses (APNs) have presented testimony to legislators on why they should be granted authority to prescribe, as provided in House Bill 667. The bill, if passed, would let APNs prescribe schedule II-V drugs, but only when working in a collaboration with a physician. Collaboration means the physician must be continuously available to communicate with the APN, either in person, or via radio, telephone or telecommunications.

So far, the reasons presented by the APNs are similar to the arguments they used in their 1996 bid for the right to prescribe. Among the reasons offered this year are:

- APNs can treat common, simple illnesses on their own, preserving a physician's time for more serious cases.
- APNs serve some of the most vulnerable population who do not currently have access to health care. One proponent testified that community health centers are located typically in areas where the family practice doctor to pa-

tient ratio is 1:3,500.

- The new bill expands the current law, passed last session, that recognizes the professional training of APNs and their collaborative arrangements with physicians. Granting APNs prescriptive authority expands this trust.

- Ohio is one of only two states remaining that does not grant some type of prescriptive authority to APNs.

"There is really nothing new, here," says Marla Eshelman Bump, associate director of OSMA's Legislation Department.

Steven Stack, a fourth-year medical student at Ohio State University College of Medicine and the immediate past president of the OSMA's Medical Student Section, presented opponent testimony that pointed out the training differences between APNs and physicians. Another key argument used by the OSMA in the past is that there has been no substantive data from the APN pilot programs that were established several years ago. The association believes legislators should review data from the

programs to substantiate claims that APNs can prescribe as effectively as physicians.

"Legislators need to hear from physicians on this issue. They need to be educated on the difference in the training between doctors and nurses," says Bump. "We need the grassroots support of our members. Call or write your representatives now and let them know that the quality of health care in Ohio could suffer if this bill is passed."

Sponsor: Rep. Richard Hodges (R-Wauseon)

OSMA position: Active opposition

Take Action

The OSMA has prepared two sample letters that you can send to your representative. For a copy of the letters, contact the *Ohio Medicine* reader response line, 1-(800) 766-6762, Ext. 6580 and ask for item #17-98.

Smoking age raised to 21

A substitute bill for Senate Bill 221, sponsored by Sen. Grace Drake (R-Solon), continues to be controversial. If passed, SB 221 would make Ohio the first state in the union to raise the legal smoking age to 21 years.

OSMA member Rob Crane, MD, with the Ohio State University Department of Family Medicine, supported the bill at a recent press conference. He reported that 40% more young people are smoking than were smoking five years ago, and said that may be due, in part, to cigarette sales to minors.

In addition to raising the smoking age, the bill also calls on local health departments to license retailers who sell tobacco products in their area. Sen. Drake is also considering a provision that would provide for the imposition of civil penalties against retailers and penalize those under 21 years who try to purchase tobacco products by revocating their driver's license or the imposition of community service. ■

OSMA position: The OSMA supports this bill.

New health-care bills introduced

HB 756

Saving the sight of Ohio's children

If this new bill passes, each time an Ohio motorist renews a driver's license, he or she will be given an opportunity to contribute \$1 to a new program that helps prevent blindness in young children. The legislation creates the "Save Our Sight" (SOS) fund, which will help identify and treat about 500,000 Ohio children who may have vision problems that are undetected or untreated. Specifically, the funds would be used to train teachers, parents and others how to screen for vision problems; support the use of protective eyewear during sports events and educate children and par-

ents on the prevention of eye injuries; and establish a "lazy eye" registry for children who have lost vision in one eye. Officials of Prevent Blindness Ohio believe an estimated 25% of schoolchildren have vision problems which affect their academic and social development.

Sponsor: Rep. Greg Jolivet (R-Hamilton)

OSMA position: The OSMA is a member of the Save Our Sight Coalition and supports this legislation.

HB 771

Insurance department wants better boards of directors

As reported in last month's *Ohio*

Medicine, this bill calls for legislation that requires Ohio-based insurance companies to appoint at least one-third of their board members from outside the company and to form board committees entirely of external members. In addition, the measure also calls for:

- Better reporting procedures, and more timely filing of financial reports;
- Approval by board directors of certain compensation packages and other payment;

- Companies to form an audit committee to review a company's financial condition;

- Outside auditors that have had its relationship with insurers terminated to notify the Ohio Department of In-

surance about the termination.

The legislation has been drafted at the request of Gov. George V. Voinovich and the Ohio Department of Insurance in the wake of the collapse of the PIE Mutual Insurance Company. ■

Sponsor: Rep. William Batchelder (R-Medina)

OSMA position: The OSMA is monitoring the bill but has not taken a position on it.

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Quick news

Immunity extends to the year 2000...The new law (formerly House Bill 612) that exempts dentists-volunteers at school athletic events from liability in civil damages also extends the immunity for physicians who volunteer in free clinics. The physician immunity was due to expire this year. Now, immunity from civil liability will extend for physician-volunteers through Nov. 15, 2000.

Who will sit on point-of-service task force?...Substitute House Bill 99 clarifies the makeup of the legislative task force that will examine consumer access to preferred provider plans, point-of-service-plans and other open-panel plans. Under the substitute bill, the task force will be comprised of two members from the Senate and House (one from each political party); two health-care providers; two health-insurance providers; two employers (one representing small business, the other large business); and two consumer representatives. The director of the Ohio Department of Insurance will serve as an ex-officio member. House Bill 99 has passed the House and is now being heard in the Senate.

Licensed physicians can diagnose mental health...All licensed physicians, including family physicians and other medical specialties (in addition to psychiatry) are among the professionals named in House Bill 718 as authorized to diagnose and treat severe mental illnesses. A list of professionals has been added to this new mental health parity bill primarily as a means to determine which mental-health costs would be covered by payors and employers. In May, *Ohio Medicine* presented the list of professionals authorized to diagnose mental health but omitted licensed physicians from the list.

"Input needed" on hastening death...Hearings continue on House Bill 660, which creates the offense of hastening a patient's death to procure an anatomical gift, but one proponent, a deputy prosecutor from Cuyahoga County, says medical profes-

sionals should be consulted before the bill proceeds further, since statutes that cover these situations are murky, both medically and ethically. A representative of the Ohio Prosecuting Attorneys Association says his group opposes the bill because current statutes already cover such situations adequately. If the facts of the case point to murder, says this representative, parties will be prosecuted regardless of the motivation – even if the patient had only five minutes of life left.

House passes defibrillator bill...The House has passed a bill that promotes the use of automated external defibrillation (AEDs) devices on heart attack victims. The bill, House Bill 717, sponsored by Rep. Rose Vesper (R-Richmond) provides civil immunity to those individuals who have been trained in the use of an AED, who have completed a course in cardiopulmonary resuscitation, and who have used the AED in good faith. Physicians are also given civil immunity if they prescribe the use of an AED or consult with others regarding its use and maintenance. The American Heart Association estimates that 100,000 of 350,000 deaths that occur annually due to cardiac arrest could have been prevented if the victim had been defibrillated in a timely manner. The bill is on the fast track in the Senate and could be law soon.

Newborn screening bill is amended...Two amendments were added to Senate Bill 241, the measure revising the rules that require the screening of newborn infants for genetic, endocrine and metabolic disorders. The first amendment calls for the Public Health Council to adopt rules regarding notices to certain individuals who cause the child to be screened. The second amendment provides civil immunity for those who conduct the tests and report the results. ■

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HB 354

Expect new DNR protocols by fall

House Bill 354, the legislation that establishes a statewide Do-Not-Resuscitate (DNR) protocol, becomes effective July 9.

Currently, the Ohio Department of Health (ODH) is meeting to draft the guidelines or protocol, established under the new law. "The OSMA will have a voice in these proceedings," says Marla Eshelman Bump, OSMA Department of Legislation who monitored the bill's progress through the Statehouse. David Romano, MD, Beavercreek, will have a seat at the ODH table as the guidelines are drafted.

The OSMA was one member of a coalition of health-care groups who saw the need for a statewide DNR protocol and came together to draft the bill.

"You can expect to see the new DNR protocols come to you, probably this fall," says Bump.

In addition to the protocols the new law also allows DNR orders to be attached to living wills, allowing Ohio patients to express, for the first time, their wishes regarding resuscitation efforts. By attaching a DNR order to a living will, the law sets some parameters as to when DNR orders will be effective. They won't be issued indiscriminately. ■

Sponsor: Rep. George Terwilliger (R-Maineville)

OSMA Position: Active support.

Who is authorized to use lasers?

The use of lasers, and who is authorized to use them, is triggering more discussion at the State Medical Board of Ohio.

The board's Limited Branch Committee is deciding what kind of guidance should be given to cosmetic therapy professionals who wish to expand their scope of practice to include the use of lasers. These professionals use lasers to remove unwanted hair and some, who are working under the direction of plastic surgeons, use laser devices for epilation.

Meanwhile, the Minimal Standards of Care Committee is considering promulgating rules on who may be authorized to use lasers. While the committee has just begun to study the issue, almost 30 other states already have rules and regulations about laser use, and the board intends to look at those as it proceeds with its investigation. One board member suggested that legislation may have to be drafted on the subject since the board itself could not require certification for lasers if that's the direction the board decides to take.

Another board member pointed out that laser equipment needs to be cali-

Medical Board Report

brated, but there is currently no state oversight of lasers that insures this is done (as there is now with X-ray equipment.) Without periodic checking to ensure the laser is working properly, patients may be seriously harmed.

The potential liability of using lasers may have prevented wider use of the device, noted one board member, but some of the newer models are less risky than previous models, so use may increase. Another board member noted that there are a number of sales staff who are out in the field promoting lasers for physician practices.

The public's perception is that lasers are pain-free and allow for faster healing, but one board member said he used to teach courses on the use of lasers, and that his first lecture centered on the number of complications that can occur.

Ohio Medicine will continue to follow this developing issue.

Of note...

Pain rules need more input...The board's proposed rules concerning intractable pain were given a public hearing in June. One of the more controversial provisions concerned whether or not a physician who believes a patient is suffering from addiction should be required to refer the patient to a substance abuse specialist for diagnosis or treatment. The OSMA has asked what happens to a physician

who must assume this burden, but the patient is unable to see someone else or is unable to find a substance abuse specialist available in the area. Several board members stated that the physician's responsibility is to refer the patient to an abuse specialist and to make the appointment for the patient. What happens after that is not the referring physician's responsibility. Ultimately, the board decided to request further input on this matter from other physicians during the rule-hearing process. ■

Group must pay fired doctor

Thomas W. Self, MD, received a \$241.75 million award from a California jury as a result of his suit against a medical group that fired him for spending too much time with patients and ordering too many tests. The jury agreed with Dr. Self that the medical group violated California law when it fired him for advocating the best care

for his patients.

Although the verdict was against a medical group, legal observers noted the case should be a warning sign to health plans that put financial considerations over the physician-patient relationship.

The jury has yet to decide if punitive damages will be awarded. ■

Three physicians sue guaranty association over PIE liquidation

Three physicians have filed suit against the Ohio Insurance Guaranty Association, charging that certain statutes that govern the liquidation of the PIE Mutual Insurance Company, as well as a recent court order terminating their PIE malpractice insurance policies, are unconstitutional.

The suit was filed by the Cleveland law firm Waldbecker, Coyne & Associates Co., LPA on behalf of Quentin Kenoyer, MD, Willoughby Hills; Earl Brightman, MD, Indian Wells, California; and Robert Hughes, MD, Cleveland. The suit will be heard in the U.S. District Court, Northern District.

The doctors allege that the statutes and court order arbitrarily discriminate against them, deny them their right to due process, and leave them self-insured for any medical malpractice claims which may be filed.

The doctors are seeking an order that declares they have until March 23, 1999 to submit notice of any claims filed against them, and that they may participate in the Guaranty Association fund. ■

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As of Oct. 1, 1998, all health plans will be required to use the same standardized credentialing form. Presently, the Ohio Department of Insurance (which has been given the responsibility of developing the form) is preparing a draft based on examples of other credentialing forms provided by the AMA, the insurance industry and health plans. The ODI is working with the cooperation of both the OSMA

and the Ohio Association of Health Plans to arrive at a final form for credentialing and recredentialing Ohio physicians. Once the form is approved and prescribed by the ODI, plans have 120 days to put it to use.

The single form is expected to reduce the amount of paperwork that is required from physicians, and the hope is that it will also reduce the time of the credentialing process. According to the statute, plans are to notify providers of the status of their application within 120 days of the plan's receiving the completed credentialing form. If there are extenuating circumstances which prevent the plan from considering the application, providers must be notified of the delay.

Basic information – for example, your DEA number, malpractice history, medical school information, etc. – will be included in the ODI's standard

format. However, health plans are authorized to ask you for additional information outside of this basic format, if the information is needed for the plan's credentialing process. Also, the law states that a plan may take into consideration the quality and appropriateness of care you deliver and a plan may use economic profiling as a factor in credentialing a provider, but only if the plan considers the case mix, the severity of illness and the age of the physician's patients.

If you have questions about this provision, or about the PHPPA in general, contact Tim Maglione, director, OSMA Department of Legislation. 1-(800) 766-6762, Ext. 6746. ■

When can you waive co-pays, deductibles?

How can you legally waive a co-pay and/or deductible for a patient, a colleague or a family member?

The law on this topic can be complex so the OSMA's Division of Legal Affairs has prepared a fact sheet on the subject that covers what physicians need to know about the implications of waiving insurance co-pays and deductibles under federal and state law.

If you regularly engage in the practice of waiving co-payments and deductibles you should be aware that recent changes to the rules governing federal health programs and new provisions in third-party payor contracts have made these common practices problematic and illegal. ■

Take Action

To order a copy of the OSMA's newest fact sheet, "Waiving Co-payments & Deductibles", contact the OSMA reader response line, 1-(800) 766-6762, Ext. 6580 and ask for item #18-98.

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Ohio Perinatal Foundation seeks enrollees

Senate Bill 50 requires certain services to collect data to ensure the delivery of quality care.

The Ohio Perinatal Quality Foundation is seeking members who provide maternity or neonatal services to enroll in a data collection and standardized reporting system that will be used to create a benchmark for measuring quality perinatal care.

The foundation is a collaboration between the OSMA and OHA: The

Association for Hospitals and Health Systems. Modeled after the Cardiac Quality Care Foundation (another joint project of the OSMA-OHA), it is the only organization of its kind dedicated to providing access to quality perinatal care in Ohio. Both foundations grew out of Senate Bill 50 (SB 50), the law that dismantled Ohio's certificate-of-need process. That law requires certain services to collect data to ensure the delivery of quality care. It's important to know that data collected by the foundation will be risk-adjusted before any results are made public.



The foundation is directed by a 17-member board of trustees and represents Ohio's six perinatal regions and all levels of service within the state. It's endorsed by the Ohio Section, American College of Obstetricians and Gynecologists and the Ohio Chapter, American Academy of Pediatrics, as well as the OHA and OSMA.

Membership is voluntary and member organizations pay the foundation \$3 per birth or neonatal admission. The foundation's goal is to achieve 100% participation of Ohio health-care institutions.

Currently, multiple-use data collection software is under development, which will allow standardized reporting for SB 50 quality assurance requirements, maternity licensure, APGAR, C-section, NTISS and electronic birth certificates. Training on the software is scheduled to begin this fall.

For more information about the program contact David Engler, vice-president of Research and Educational Foundation for OHA at (614) 221-7614. ■

Insurer taken to court over denial of care

A Johnstown man is suing Anthem Blue Cross/Blue Shield of Cincinnati for denying coverage for treatment of his wife's brain tumors. She died before the appeals process was settled, but the insurer's denial arrived one day after the woman's funeral.

The case is similar to the Ross county widower who is suing CIGNA Healthcare of Ohio after the insurer refused to cover a new surgical treatment for liver cancer, calling the procedure experimental. The man (along with his wife) sued CIGNA to force the company to pay for the treatment. CIGNA appealed on the grounds that the health insurance contract calls for disputes to be settled by arbitration. The policyholder died while the matter was pending, but the suit was continued by her husband on his wife's behalf. As *Ohio Medicine* reported last month, the Ohio Supreme Court ruled that, in this case, the insurer could be sued in court by the husband because CIGNA's arbitration provision was ambiguous. What the court did not address in its decision was what constitutes a "meaningful response in a timely fashion". "That decision will have to wait for another day," the court wrote.

Whether or not that question will be addressed in this case remains to be seen. This widower wants at least \$50,000 from Anthem on behalf of himself and three adult children on claims of wrongful death, intentional infliction of emotional distress, bad faith and breach of contract.

Although Anthem denied the brain chemotherapy treatment after three procedures were performed, the insurer did cover the costs of a more conventional and less expensive treatment. The man, however, said those treatments were less effective. ■

October 2, 1998

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Volunteer physicians needed for SSI evaluation

Last month, *Ohio Medicine* reported on concerns about access to providers if Ohio continues to expand its coverage to uninsured children through the state Children's Health Insurance Program (CHIP). Now, news reports suggest that uninsured children are not flocking to the state's present Medicaid expansion for health-care coverage.

Initially, state Medicaid officials estimated it would add 133,000 children to its Medicaid rolls when the program was expanded in January to families with incomes up to 150% of the federal poverty level. So far, however, less than 30,000 children have been added — most from families whose younger children were on Medicare already.

The state is taking aggressive steps to spread the word to those families it has not yet reached. A Medicaid hot line has been created to help answer questions and provide more information. It's staffed from 8 a.m. to 8 p.m. daily. County agencies, boosted with federal money, are increasing their outreach methods. The state Medicaid office has also mailed information about the expanded health-care coverage for children to those families who receive benefits through the women, infant and children nutrition programs. The Medicaid application form has been simplified as well.

Some states, in an effort to remove the stigma often associated with government health plans, are renaming their child-health insurance programs or revamping them to make them look more like private insurance plans.

Currently, Ohio's Medicaid program serves about 557,000 children. ■

Take Action

If you know of families whose children may qualify under Ohio's new, expanded Medicare program, have them call 1-(800) 324-8680 for more information.

Ohio expands coverage; but where are the kids?

Last July, federal changes to the Supplemental Security Income (SSI) program took effect. These new rules call for a child to have a "medically determinable physical or mental impairment which results in marked and severe financial limitations."

Before the revised standards were put into place, about 55,000 Ohio children qualified for an average of \$417 in monthly benefits. Since last July, about 3,992 children, or about 6% of those formerly eligible have been dropped from the program.

Families have 60 days to appeal the ineligibility decision, and the Ohio Legal Assistance Foundation (OLAF) has a number of attorneys throughout the state who have volunteered to help with these appeals. A toll-free hot line has been established to provide more information on the process and to link families who wish to appeal a decision with a volunteer attorney. The number is 1-(888) 601-KIDS.

Now, Beth Short with the OLAF has notified the OSMA that volunteer physicians are needed to perform independent evaluations on those children whose appeals have been denied.

The OSMA has been actively involved on this issue, and, last year, President Su-Pa Kang, MD, sent a letter to the Ohio Department of Human Services encouraging that agency to do everything possible to see that these children retain their eligibility. ■

Take Action

If you can volunteer some time to help families who are appealing ineligibility decisions, please contact: Lynn Burns, OLAF, 1-(800) 877-9772.

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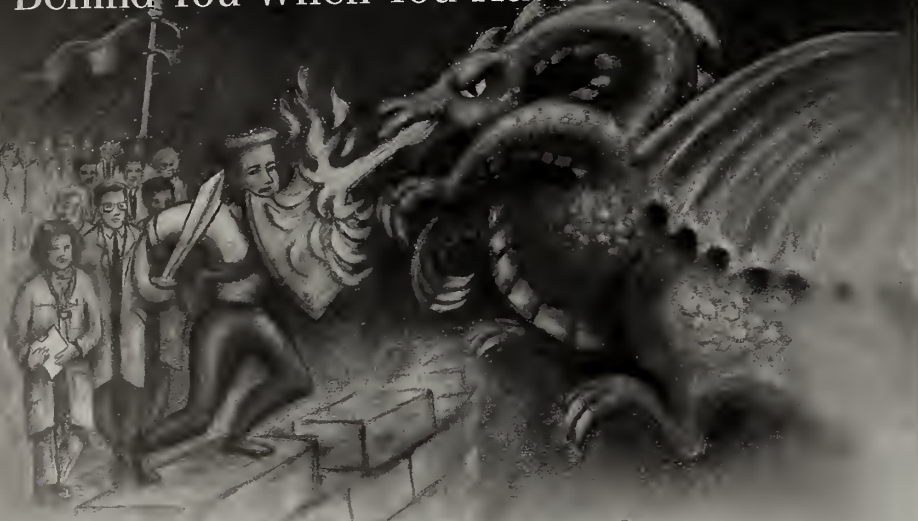
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Marion is safe community despite ODH leukemia report

By Brooks H. Sitterley, MD

The article on the leukemia rates in Marion, Ohio in the May issue of *Ohio Medicine* leaves the impression that a problem exists in Marion. This is not the case. Three to four years ago, several students at the county high school, River Valley, developed leukemia over a two-year period. The families organized and wrote letters to many politicians suggesting a reason must exist for the clusters of cases. The Ohio Department of Health (ODH) became involved. They looked up death certificate deaths in three 10-year periods in Marion — 1966-1975, 1976-1985, and 1986-1995. The death certificates showed 21 deaths, 24 deaths and 46 deaths in the city of Marion. The figures for the whole county were 40, 45, and 66 for each period. The ODH used the most spectacular number of a jump from 21 to 46 or 122% increase. These figures are probably incorrect. Thirty years ago, many physicians in Marion County signed the cause of death certificates as cardiovascular collapse. If leukemia was present, it might not have been mentioned. We did not have a medical oncologist in town to diagnose the subtle acute cases which may have died of acute infection. How many cases could have been reported?

The American Cancer Society publishes a list of incidence and mortality each year. In 1991, for instance, Ohio was projected to have 850 deaths by leukemia. Marion County is about 5.2% of Ohio population so that 53 deaths should have been recorded. Over a 10-year period, this would be about 53 deaths per year. The ACS figures are valid collections from multiple cancer registries. We, in Marion County, are guilty of not reporting the

Second Opinion

correct number of leukemia deaths; more so in the first two collection periods than the last, as medical oncologists became members of this county society. The ODH failed to calculate what the true incidence of disease might have been.

In July 1996, the ODH first published "Cancer Incidence Among Ohio Residents 1992." The summary for leukemia indicated three health-service areas and 18 counties were significantly higher than the Ohio rates (<0.05). 15 counties had a higher incidence of leukemia than Marion County with Paulding County over 214% higher.

How many cases of leukemia should we expect? The ODH report suggests this USA incidence is 9.9/100,000 but Ohio is much better at 8.1/100,000. Neither agree with the ACS which suggests 1,200 new cases/year in Ohio. Since the Ohio population is 11 million, this is in incidence of 10.9/100,000. Marion County has had the following incidences: 1992 — 8; 1993 — 7; 1994 — 7; 1995 — 8; 1996 — 7. The ODH has frantically tried to find more cases. As soon as a larger population base is used, this incidence should increase.

Thousands of dollars have been spent trying to find a cause for something that does not exist. Our cancer registry shows different types of leukemia arising each year, which accounts for the clusters of River Valley cases. The causes of leukemia are varied and include viral and genetic etiology.

Marion County has suffered from this campaign to label us as a leukemia

center. Businesses have not located in our community. Home buyers have not been able to get mortgages for their homes. The unfortunate families of the students with leukemia have lashed out against all who try to inform the public of the true facts. Local physicians have not stood up and been counted.

Is there anyone in the Ohio State Medical Association who will stand up and state that Marion is a safe community?

Brooks H. Sitterley, MD, is chair of the Cancer Committee at Marion General Hospital.

Coding alert

To the Editor:

I would like to alert you to the existence of almost-fraudulent Medicare coding seminars in our area. The seminar proved to be one large, high-pressure sales pitch for a series of three soft-cover Medicare "tips" books for \$377.77. The books were sealed in plastic wrap and unavailable for close examination. Very little information was imparted in the lecture portion of the seminar. No one was allowed to speak up and raise questions. The seminar I attended was sponsored by a California company. The fee for the seminar itself was \$97. Even more troubling was the amount of productive time being wasted on attendance at the seminars. I spoke to several office managers who felt they did not have the authority to leave early, based on their own judgment of its worth.

Scott M. Nelson, MD,
Mentor

See page 1 story for OSMA-sponsored coding seminars.

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OSMA News



OSMA members will have greater voice as result of Task Force 2000

Have a concern you want your association to address? The process for putting that issue before OSMA decision-makers just became easier – thanks to the work of the Task Force 2000.

The task force's report recommended ways to make the OSMA more responsive to member needs, and those sections were adopted by the association's House of Delegates in May. Before these provisions were adopted, a member would have to wait until the House convened each year to have a concern addressed. Now, any member, at any time, can bring the issue before the OSMA Council for consideration. This includes individual members, and members of local/regional societies as well as specialty societies.

If the councilors feel qualified, and they have the appropriate background information to make an informed decision on the matter, the OSMA's response to your concern will be immediate. However, if the Council believes more research or information is needed, the matter will be assigned to an appropriate Focused Task Force (FTF) for discussion and recommendation.

Focused task forces are new

Focused Task Forces are a new tool for the OSMA – and they serve two purposes. First, they are a way for the association to expand member involvement. These new task forces will be used in addition to OSMA's standing committees, thereby increasing the opportunities for physicians to participate on the issues that are important to them. Second, the task forces will enable more in-depth study on those subjects that are of concern to members. FTFs will propose policy, analyze issues and take whatever action may be called for to accomplish goals in their areas of responsibility and expertise. The FTFs may es-

tablish ad hoc working groups and task forces of their own, and may consult with experts as needed – including non-members and even nonphysicians. The FTF chair may also be invited to attend those Council meetings where work from his or her task force is being addressed.

It's important to note that, while FTFs will make recommendations to Council, and while Council will act on those recommendations – no policy decisions made by Council in the interim between Annual Meetings will be allowed to contradict any OSMA policy already set by the House of Delegates. Reports of actions taken by Council will be prepared for members periodically, and an official report of the Council's interim actions will be presented to the House of Delegates at its next meeting.

Increased member communications

In addition to more timely responses to member concerns, the OSMA will also work to make its communications with members more effective. While your association will continue to provide you important information through traditional forms like *Ohio Medicine*, and *Medical Staff Bulletin*, you can also expect to see more development of the OSMA Web site in the future. The Internet is an expedient way to give you the information you need to know now, but it's also an excellent way for you to provide the OSMA with your input and feedback. Check out the "Bulletin Board" the next time you visit www.osma.org and let OSMA members know what you're thinking on any topic that's important to you (the "bulletin board" is accessible only to members.) OSMA Councilors have indicated they check OSMA's Web site frequently, so if you post a concern on the bulletin board, it will be heard by both councilors and of-



Patrick McCormick, MD, Toledo, shares his views on the Task Force 2000 report of the Annual Meeting.

ficers of your association.

Web site development is not the only new method the OSMA is developing to enhance member communications. The association is also exploring the possibility of a regional service office for those counties where no full-time county medical society exists – and hiring more "regional representatives" or field service staff to provide support to one or more membership regions of the OSMA. This position will serve as a liaison between the OSMA and the county medical societies of that region. This project is actually underway as a pilot program in Northeastern Ohio. OSMA staff member Ben Reynolds serves as the liaison between physicians in that area, their county societies and the OSMA.

With these changes, recommended by the Task Force 2000, the OSMA will be better able to respond to the expressed needs of its membership than at any other time in the past. These policies will help your association be more relevant and vital – and attentive to your needs, no matter what they may be. ■

Wielkiewicz announces candidacy

Eighth District Councilor Walter J. Wielkiewicz, MD, has announced his candidacy for the office of president-elect of the Ohio State Medical Association. If elected, he would become president-elect in 1999 and OSMA president in the year 2000.



Dr. Wielkiewicz

Dr. Wielkiewicz is a family physician in Zanesville. He received his medical degree from the University of Cincinnati College of Medicine in 1984 and completed his postgraduate work in family medicine at Miami Valley Hospital in Dayton.

In addition to his membership in the Muskingum County Medical Society and the OSMA, he is also a member of the AMA, the American Academy of Family Practice and the Ohio Academy of Family Physicians, the Muskingum Valley Academy of Family Physicians and the American College of Sports Medicine.

Dr. Wielkiewicz has served as a delegate to the OSMA for seven years, and as Eighth District Councilor for three years. He was also a member of the OSMA's Task Force 2000 and currently chairs the OSMA Auditing and Appropriations Committee.

He has been nominated and unanimously endorsed by both the Muskingum County Medical Association and the OSMA's Young Physicians Committee.

"Dr. Wielkiewicz is an innovative, dedicated leader and outstanding advocate for organized medicine," writes Vincent M. Gioia, MD, chair of the OSMA Young Physicians Committee. ■

Organized medicine tackles E&M guidelines – and wins

You don't need to look further than this year's OSMA Annual Meeting to see just how frustrated physicians are with the E&M documentation guidelines proposed by HCFA. Five resolutions on the topic were rolled into one substitute resolution that we took to the AMA Annual Meeting last month.

It's to organized medicine's credit, however, that we have insisted on changes to make guidelines more workable. In May, representatives from county, state and specialty societies (including yours truly) flew into Chicago to meet with officials from both the AMA and HCFA to



Lance Talmage, MD

discuss how the guidelines could be revised to make them in line with physicians' thought processes. HCFA decided, at that time, to delay the implementation of the guidelines until they could work out the kinks that had been created for practicing physicians.

We're grateful, of course, for the interlude, and for the promise that the guidelines will be made practical. We're delighted to hear they will be road-tested in a pilot project that will enable physicians to further modify and improve the guidelines. Many specialty societies are currently working in cooperation with the AMA to form templates and other aids that will allow the doctor to document in such a way that he or she can legitimately bill for services rendered at an appropriate level. We're also happy that the Office of the Inspector General and HCFA promise that there will not be accusations of fraud and abuse for inadvertent billing errors and honest differences of interpretation of rules.

In the meantime, however, we all need to be aware that, sooner or later, guidelines – in their final form – will need to be followed. The guide-

President's Perspectives

lines of 1994-95 are inadequate and put physicians at more risk for accusations of fraud and abuse.

Proper documentation of billing, done in an efficient and logical way, can be to your benefit to document and bill correctly. If you don't believe me, see the front page story on the OSMA's E&M documentation seminars for an example of how one member improved his situation substantially with a little education.

Education is important – in fact it's necessary if we are to use guidelines properly and to our benefit. Again, that's where organized medicine has stepped in to help you. Starting this fall, the OSMA will present half-day seminars to familiarize you with the level of documentation needed to meet the requirements of new guidelines. Let me remind you that these presentations are best approached with an open mind. If you attend with the idea that guidelines should be eliminated entirely, you won't derive as much from the seminars as you should. Please come with the expectation that some guidelines will be implemented, sooner or later – then allow us to tell you how to use them to benefit your practice.

If your nonmember colleagues have asked you, lately, why they should pay dues to the OSMA, tell them about our E&M documentation seminars. Tell them about the May fly-in where organized medicine came together to present its concerns to the government – and achieved results on their behalf. Then ask them how they can afford to be nonmembers. (P.S. You might just have a member application blank handy.) ■

OSMA elects new officers, councilors

David J. Utlak, MD, Canton, was named OSMA's president-elect. Dr. Utlak, former Sixth District Councilor, ran unopposed for the position and was elected by acclamation. In other election results, the following individuals were elected to the OSMA Council for two-year terms.

Councilors

District 1: Walter E. Matern, MD, Cincinnati

District 2: Alan H. Klein, MD, Dayton

District 3: Walter E. Beasley, III, MD, Marion

District 5: Daniel W. van Heeckeren, MD, Cleveland

District 6: Chris A. Knight, MD, Youngstown

District 7: Daniel J. Clemens, MD, Dover

District 9: Carol M. Sholtis, MD, Gallipolis

District 11: W. Jeanne McKibben, MD, Oberlin

Delegates to the AMA
(Term: Jan. 1, 1999 to Dec. 31, 2000)
Walter E. Matern, MD
J. Steven Poksley, MD
Walter A. Reiling, Jr., MD
Carol M. Sholtis, MD
Lance A. Talmage, MD
Daniel W. van Heeckeren, MD
Richard J. Wiseley, MD

Alternate Delegates to the AMA
(Term: Jan. 1, 1999 to Dec. 31, 2000)
Steven P. Combs, MD
Charles J. Hickey, MD
Susan L. Hubbell, MD
W. Scott Nekrosius, MD
William C. Stenfeld, MD
James M. Sudimack, MD

Alternate Delegate to the AMA
(Term: May 17, 1998 to Dec. 31, 1999)
Richard N. Nelson, MD

Alternate Delegate to the AMA
(Term: Jan. 1, 1999 to Dec. 31, 1999)
Andres B. Lao, MD

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OSMA to send state issues to AMA in more timely fashion

One of the adopted resolutions at this year's Annual Meeting will mean that the Ohio delegation can be more effective at bringing issues concerning Ohio physicians to the AMA's attention.

Issues of concern to Ohio physicians no longer have to risk being lost in the shuffle at national AMA meetings, thanks to action taken at the Ohio State Medical Association meeting in May.

The OSMA passed a resolution authorizing state delegates to the AMA to bring issues up at the national association's meetings without first receiving approval at the state meeting.

OSMA's late spring meeting date left too little time to properly prepare approved issues for presentation at the Annual AMA Meeting, which typically is held in June. Also, issues that were approved here were submitted to the AMA too late for inclusion in the packets of preview materials prepared

for the national meeting participants. Instead, Ohio physicians' concerns were made available to AMA delegates on the day of the vote.

"This did not provide sufficient time for adequate review and consideration of our issues," said Walter A. Reiling Jr., MD, chair of the Ohio delegation to the AMA. The former procedure was particularly troublesome this year as the national meeting was moved up a week or so.

Requiring prior approval at the state's Annual Meeting also meant that issues surfacing between the May meeting and AMA's winter meeting could not be presented for consideration at that time, he said.

The new procedure enables Ohio physicians to have issues of concern brought by their state delegates to the national forum on a more timely basis.

"It's also important for our physicians to remember that they can present their concerns for consideration to our governing council or our delegates to the AMA at any time of the year," Dr. Reiling said.

Issues will be brought to the next

Annual AMA Meeting as long as they:

- are approved by the OSMA Governing Council and
- do not contradict OSMA policies.

All issues brought up in this manner will be presented to the OSMA House of Delegates at the state association's next Annual Meeting, Dr. Reiling said.

The Ohio delegates were also authorized to rewrite and gather necessary background information for issues approved at the state meeting in May for presentation in Chicago.

"This new procedure will enable us to present our physicians' issues to the national forum in a more effective, timely manner," Dr. Reiling said. — Anna Rzewnicki

Members elected to AMA posts

During the AMA's Annual Meeting in June, three members of the Ohio State Medical Association were elected to positions in the American Medical Association's House of Delegates. They are: Stephen L. House, MD, elected alternate delegate from the AMA's Organized Medical Staff Section; Peter Hazelton, OSU College of Medicine who will serve as an alternate delegate from the AMA's Medical Student Section; and Heidi Dunninway, MD, re-elected vice-chair of the AMA's Resident Physician Section. Jack Summers, MD, Akron, lost his

bid to serve on the AMA's Council on Medical Education.

E. Ratcliffe "Andy" Anderson, Jr., MD, was introduced to the AMA's House of Delegates in June as the association's new chief executive.

Dr. Anderson is the former U.S. Air Force Surgeon General and, until he assumed his new position, served as the chief executive officer of Truman Health Systems, as well as a professor of medicine at the University of Missouri-Kansas City School of Medicine.

Dr. Anderson is married and has three children. ■

Outcome of Ohio's resolutions to the AMA

This year, the Ohio delegation took six resolutions to the American Medical Association's Annual House of Delegates Meeting in June. The Ohio resolutions came from the OSMA's own House of Delegates meeting held this past May in Cleveland.

The six resolutions taken to the meeting and their outcomes are as follows:

AMA Resolution 138

Protest Announced Medicare Payment Delay

Outcome: Amended, adopted

AMA Resolution 139

Request for Title Change of the Medicare Fiscal Intermediary Letter of Inquiry

Outcome: Adopted

AMA Resolution 521

Decrease Mortality Due to Asthma

Outcome: Adopted

AMA Resolution 846

The Definition of Global Fee Period for Surgical Procedures – Pre-operative Service Period

Outcome: Substitute Resolution 846 adopted

AMA Resolution 847

Protest of HCFA Regulations Implementing Revised Documentation Guidelines for Evaluation and Management Services

Outcome: Substitute Resolution 801 adopted as amended in lieu of Board of Trustees Report 43

AMA Resolution 848

ICD-9 Codes for Laboratory Tests

Outcome: Adopted as amended

In other actions, according to the *AMNews*, the AMA's House of Delegates voted to oppose any documentation system for the E&M guidelines that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as clinically appropriate medical record-keeping.

AMA leaders warned the house that its decision could increase the odds that the Health Care Financing Administration (HCFA) would develop its own quantitative standards and could complicate the cooperative HCFA-Federation task of creating a stan-

dard set of guidelines that are understandable to the nation's physicians.

Concern was expressed, too, over medicine's failure to produce its own alternative standards, but grassroots physician protest carried the House, and the policy against the use of bullet points and the counting of care elements to determine the appropriate level of coding was passed. ■

Let's take care of each other

(The following article has been taken from Dr. Goorey's installation speech during the OSMa Alliance Annual Meeting in May. It has been edited slightly for physician readers.)



Nancy Goorey, DDS

As Alliance President, my theme for this year is "Getting to Know You." I want us to know each other, not simply by the office we hold, but who we really are – our families our hobbies, our interests and our common bonds.

We can only be useful to medicine if we are truly bound together by the ties that are our shared values and beliefs.

Values:

- We value this extended family of which we are a part.
- We value this profession, which has provided us with a way of life we cherish.
- We value the support and friendships we have found.

Team physicians honored

This year, the OSMa recognized four "Outstanding Team Physicians" – all OSMa members – who have donated their time as team physicians to high school athletic teams around the state. The four are:

• **Glenn E. Eippert, MD**, has given nearly 30 years of service to the students of Edgewood Senior High. A family practitioner at Ashtabula Clinic, Dr. Eippert is also a past president of the Ashtabula County Medical Society.

• **Leonard J. Janchar, MD**, Marietta, has served for 22 years as a team physician for Ridgedale High School. A pediatrician, Dr. Janchar is a member of the OSMa's Joint Advisory Committee on Sports Medicine, and is

Alliance Report

Beliefs:

- We believe that we can improve the quality of life for our communities.
- We believe that we can help shape change.
- We believe that we can be a source of strength for our spouses through medicine's changes and challenges.

We are all volunteers who have a commitment to give something back for our good fortunes, and this binds us together. We are a voice and a face for medicine in our communities, and this binds us together. We are the glue that holds our organization tight and firm. These things we value...and we believe...and we share.

Dennis's challenge to Alliance members was to "take care of your county," and I think that has been accomplished. My hope is that, now, we take care of each other, and that is my goal for the year. ■

active in the Ohio Chapter, American Academy of Pediatrics.

• **John E. Rosso, MD**, Willard, has tended to the needs of student athletes at Willard High School for more than 30 years. A family practice physician, Dr. Rosso works at the Willard Medical Center and is also a past president of the Huron County Medical Society.

• **Barry Webb, MD**, Cincinnati, became involved as a team physician for Princeton High School 21 years ago. A family physician, Dr. Webb is also a member of the Sports Medicine Committee of the Ohio Academy of Family Physicians, and is a past president of the Southwestern Ohio Society of Family Physicians. ■

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Billing seminars scheduled

Throughout August and September, the OSMa will sponsor, once again, its popular Medicare and Medicaid billing seminars, designed to give physicians and their office staffs the newest Medicare and Medicaid policy changes, as well as time-saving hints on how to bill these government-sponsored programs. General review topics will include documentation, proper billing guidelines and changes in reimbursement procedures for various specialties.

Faculty will include members of the Training and Provider Relations staff from both Medicare and Medicaid.

Cost is \$50 for members, \$75 for nonmembers and includes materials and refreshments.

Choose from the following locations and dates:

A.M. Session only, 8 a.m. – noon, registration opens at 7:30 a.m.

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• **Thursday, Aug. 27**
Cambridge
Holiday Inn
2248 Southgate Parkway
Cambridge, OH

• **Wednesday, Sept. 2**
Elyria
Holiday Inn
1825 Lorain Blvd.
Elyria, OH

• **Thursday, Sept. 3**
Mansfield
Comfort Inn
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Mansfield, OH

A.M. and P.M. Sessions 8 a.m. – noon, registration at 7:30 a.m.; 1-4 p.m., registration at 12:30 p.m.

• **Wednesday, Aug. 5**
Perrysburg
Holiday Inn
10630 Fremont Pike
Perrysburg, OH

• **Thursday, Aug. 13**
Boardman
Holiday Inn
7410 South Ave.
Boardman, OH

• **Thursday, Aug. 20**
Dayton
Dayton Marriott
1414 Patterson Blvd.
Dayton, OH

• **Wednesday, Aug. 26**
Canton
Holiday Inn
4520 Everhard Rd. NW
Canton, OH

• **Wednesday, Sept. 9**
Cuyahoga Falls
Sheraton Suites Hotel
1989 Front St.
Cuyahoga Falls, OH

• **Thursday, Sept. 17**
Cincinnati
Cincinnati Marriott
11320 Chester Rd.
Cincinnati, OH

• **Wednesday, Sept. 23**
Columbus
OSMA Headquarters
3401 Mill Run Drive
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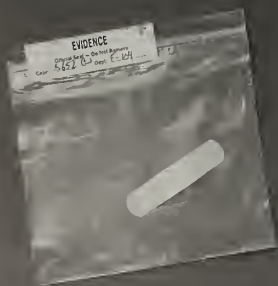


Exhibit A:

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Lessons from successful physician networks

Physicians can form successful networks if they keep focused on their goals, make themselves aware of the changing marketplace – and don't believe their own publicity.

That's the advice Ron Fasano, president and chief executive officer of the Eastern Ohio Physician Organization (EOPO), gave to members and guests of the Organized Medical Staff Section (OMSS) at the section's Annual Meeting in May.

The EOPO is a for-profit, physician-owned, managed-care network that grew out of a steering committee and work-group formed by the Mahoning County Medical Society in 1994. From there, the network has grown to a corporation that, last year, had an asset base of over \$5 million, (60% of the income from nonphysician sources), and a managed-care membership of 45,000 (including both HMO and PPO enrollment.)

Fasano provided the following "lessons learned" along the way to success:

1. Stay focused on your mission.

From the beginning, says Fasano, the EOPO had a mission statement: "To provide quality, cost-effective care for a community while supporting the private practice of medicine."

"It's important to stay focused on that mission," says Fasano, because it helps you avoid future mistakes – mistakes like growing the network at any cost. First, ensure the reliability of your network then push the envelope.

2. Have an investment philosophy.

Make certain all network participants ascribe to the same principles and beliefs of investing in the network, whether the capital is for human or technological expansion.

3. Develop market awareness.

"It's essential," says Fasano. Payors shift, other networks (your competitors) promise big things. "Even your own members may not be true-blue to your network," he says. You should be aware of what is occurring in the marketplace so you can take steps to compete, compensate, or correct.

4. Communicate.

Communicate continually, communicate simply. Document the value of your network to employers, other providers, and the public. Team up with office personnel to hear what they have to say. Listen to patients. Your network can only improve as a result.

5. Be humble.

In other words, says Fasano, don't believe your own publicity. Instead, stay focused on your mission and on helping your patients.

Next month Ohio Medicine will present more advice on forming successful physician networks from Thomas Wolff, MD, manager, Physician Networks and Contracting Services with Michigan Medical Advantage.

Take Action

For copies of Ron Fasano's presentation and the other presenters at the Organized Medical Staff Section's Annual Meeting, contact Shar Wackman, 1-(800) 766-6762, Ext. 6773. Cost for the tapes is \$11.50.

Humana/United HealthCare merge

United HealthCare Corp. will merge with Humana, Inc., creating one of the country's largest managed-care companies.

The new, merged company will continue to operate, initially, under the United HealthCare name, and will be based in Minneapolis.

United HealthCare has 1.2 million members throughout the state; Humana has 200,000 – most of whom are in Cincinnati. United HealthCare also has a presence in the Columbus, Cleveland and Dayton marketplaces. ■

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Ohio Medicine

A Publication of the Ohio State Medical Association

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My favorite Web site...

John W. Thomas, MD

www.hotspring.com

"We've enjoyed hot tubs while on vacation and would like to enjoy their therapeutic value at home. The HotSpring Portable Spa site gives you almost more than you ever wanted to know, such as how hot tubs are designed and built at their factory. But the site makes it easier to be a smart consumer about a product most people wouldn't buy very often. For instance, the site includes a list of things to consider when comparing products.

"HotSpring is also a sponsor of the National Arthritis Foundation, with a link to their site. When I'm ready to buy a hot tub, their site will provide the nearest dealer's contact information by ZIP-code search."

What to look for: The HotSpring site uses the photogenic quality of its products to full advantage. A photo gallery of indoor and outdoor installations include settings in a snowy ski area, in a tranquil Japanese tea house and across from the Manhattan skyline.

The site is complete as imaginable, from a list of premium features to warranty information. If you're still not sure, you can order a 12-minute VCR video for viewing with a friend.

www.osma.org

"As an officer, I receive a lot of information via meetings and other regular communications. However, the OSMA Web site is always accessible to all of our busy members – particularly for legislative and regulatory updates, which is the most fundamental service area OSMA provides.

"I do hope the ease of access to information enables more members to take proactive steps on more legislation more often." – Carol Larimer

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Jury duty law being monitored

The OSMA had taken a neutral position on the bill, primarily because the bill was on the fast-track for passage and would have been signed into law with or without OSMA support.

- The demands of your business require a temporary excuse.
- You are away from the county on necessary business and won't return in time to serve.
- The interests of the public or your own interests will be materially injured if you take time

PIE proof of claim forms mailed

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of which they have received notice. Policyholders may also file a claim for return of unearned premium or recovery of surplus notes. To file for recovery of surplus notes, make sure your form TYPE is for surplus notes and check off the last box under the CLAIMANTS section. You must attach a copy of your surplus note(s) or other supporting documentation. It is not possible to file a "blanket" Proof of Claim form to cover claims that may arise in the future. If a claim arises between now and the filing deadline, you may request a Proof of Claim form in writing: Office of Ohio Insurance Liquidator, 1366 Dublin Road, Columbus, OH 43215-1093. ■

While the OSMA can not complete your Proof of Claim forms, we can respond to general questions. Contact Herb Gillen, (800) 766-6762, Ext. 6792

Two more months till managed-care reform

In just two more months, Ohio physicians will begin to experience managed-care reform in a number of ways, from standardized credentialing to new "due process" rights to more disclosure in your managed-care contracts. All of these changes are courtesy of the Physician Health Plan Partnership Act (PHPPA), the new law developed by the OSMA and Kaiser Permanente.

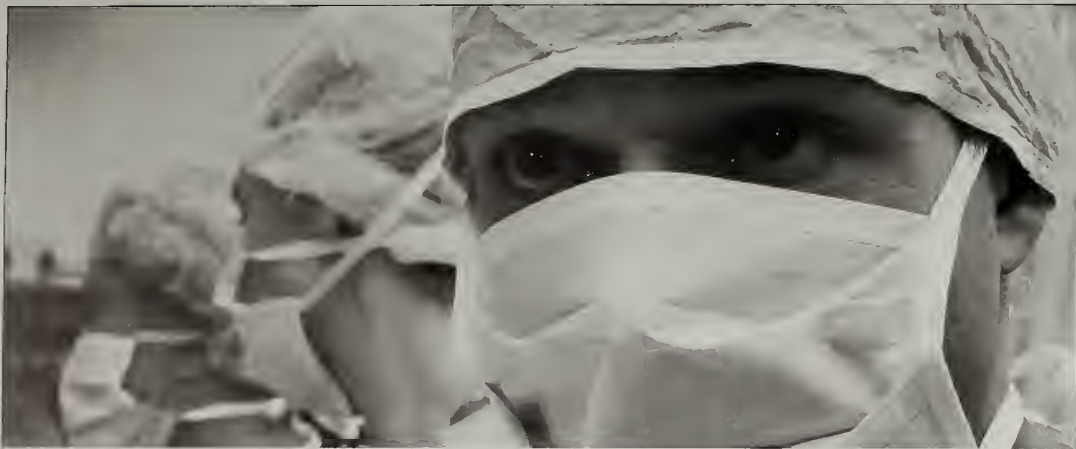
Medicine has run a column, "PHPPA Advantage," since May, outlining some of the benefits. In addition, the OSMA Division of Legal Affairs has prepared a paper that explains how your plan contracts are likely to change once the law is in place.

miliar with your new rights. Contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #27-98. You will be sent a copy of the PHPA Executive Summary. You may obtain a copy of the Legal Affairs paper regarding the law by asking for Item #20-98. ■



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Jury...

continued from page 1

- away to serve.
- You're physically unable to serve.
- Your spouse or near relative has died recently or is dangerously ill.
- You've already served as a juror for a trial in a county court that year.

If you have been called for jury duty, the OSMA believes that the most likely ground for exemption for physicians is the one relating to your interests and the interests of any others (i.e. patients) who are materially affected by your service on a jury. Physicians should be prepared to discuss the number of patients they have scheduled for the projected time period; the difficulty in rescheduling these patients in an already full schedule; the difficulty in other physicians absorbing those patients into their practices.

Reports that are received on this subject will be reported to Council. Council will determine if any further action is needed. ■

Take Action

In accordance with Resolution 05-98, the OSMA is closely monitoring the effects of the new law on both physicians and patients. If you are experiencing problems with jury duty, contact Katrina English, director of the OSMA's Division of Legal Affairs, (800) 766-6762, Ext. 6768.

Bills, Laws & Rules

Legislative review

Do you know about your new rights under the law?

Much of the health-care legislation that passed last year has a positive spin for medicine, thanks to the work of your association.

If you don't know about OSMA's legislative successes during 1997-1998, you need to read this now. Your association has scored some remarkable wins for medicine, but unless you're familiar with these new laws, you will be unable to achieve their full benefit. So look over this quick review of OSMA-supported bills that have become law over the last year and learn about your new protections. They came to you courtesy of the OSMA.

What the OSMA has won:

- A level playing field for physician-sponsored networks

Even if no one has taken advantage of the Managed-Care Uniform Licensure Act (MCULA), yet, that's OK as far as the OSMA is concerned. The victory, here, was in achieving a win for the future. Without OSMA involve-

ment, physicians in group practices or in other arrangements would have had a difficult time meeting the solvency requirements that the Ohio Department of Insurance and the HMO industry wanted to set for physician-sponsored networks. "We wanted to put in the statute that there is market value for a physician's ability to directly render care," says Nick Lashutka, OSMA Department of Legislation, who led the OSMA's efforts. As a result, HMOs must meet a minimum solvency requirement of \$1.2 million in assets; physician-sponsored networks must have a minimum of \$1 million in assets. Thanks to the OSMA, you have a level playing field if you want to sponsor a network, and, if you don't, you have the satisfaction of knowing that, in this bill anyway, legislators believe you are able to produce a higher-quality managed-care product than most insurers or other payors.

Effective date: June 4, 1997

- A physician's "bill of rights"

The Physician-Health Plan Partnership Act comes as close as possible to

total managed-care reform in Ohio, and is likely to serve as a model for the rest of the country. The OSMA created the bill through partnership with Kaiser Permanente, and it is so beneficial to physicians that *Ohio Medicine* highlights a provision each month in its "PHPPA Advantage" column to make you aware of your rights under the new law before its October effective date. Included in the new law, for example, are provisions that:

- prohibit plans or UR organizations from retroactively denying reimbursement for an approved treatment for an eligible enrollee;
- prohibit gag clauses;
- establish a defined, standardized process for resolution of patient grievances;
- allow patients with chronic conditions to have a standing referral to a specialist;
- establish a "performance improvement plan" for physicians who are about to be terminated for not complying with plan guidelines;

continued on page 4

Pages

6

APN and MD/DO training is vastly different. Steven Stock, MD, opened legislators' eyes to the difference when he presented testimony on HB 667, the measure that gives APNs prescriptive authority.

10

Anthem's request that physicians repay two-year-old overpayments that the insurer made by mistake has angered some physicians and caused the OSMA to fire off a letter to the insurer.

12

Deciding against renewing her Aetna contract was not a reimbursement issue, says Molly Katz, MD, a Cincinnati ob/gyn. Instead, her decision had everything to do with patient care.



14

Pain is difficult to treat and physicians are sometimes hesitant to prescribe the appropriate amount of painkillers because of misunderstandings with the medical board. That's why the OSMA is producing a handbook that will provide guidance on treating a variety of chronic pain situations.

PAIN

The Fifth Vital Sign

Legislative review... continued from page 3

- appeals of adverse determinations be reviewed by a clinical peer;
- require that physicians be involved in the development, implementation and evaluation of all UR and QA programs;
- require that plans with restrictive drug formularies allow physicians to prescribe nonformulary drugs if the formulary equivalent is not effective for the patient;

- require all plans to use a standard credentialing form that will be used for both credentialing and recredentialing of providers;

- require plans to provide more contract disclosure to physicians prior to their entering into a contract.

This is where you need to know your rights under this law in order to benefit. Check out this month's "PHPPA Advantage" for more information, and watch for other stories in *Ohio Medicine* on this new law.

Effective date: Oct. 1, 1998

• Clinical autonomy in corporate practices

More and more entities are emerging in the managed-care marketplace. Various health-care providers are joining together to form professional corporations, limited liability companies or other partnerships. The OSMA has had a long tradition of supporting a ban on the corporate practice of medicine – but the reality of today's marketplace is that

such arrangements are occurring, with or without OSMA's blessing. So your association decided to become involved. If these arrangements are going to take place, then physicians need to retain the ability to make individual medical treatment decisions based on their professional clinical judgment. When the bill was signed into law, the OSMA was successful in ensuring that clinical autonomy for physicians was retained.

Effective date: April 10, 1998

• Clearer protocols for DNRs, and some qualified immunity

The OSMA helped draft the do-not-resuscitate (DNR) legislation, in part to clear confusion that existed when a patient had a living will, but there was no knowledge of this on the part of other providers – a paramedic, for example. Thanks to House Bill 354, which passed earlier this year, DNR orders will now be attached to living wills, and the Ohio Department of Health is expected to produce by this fall a series of standardized protocols and guidelines for DNR orders that will be used across the state. The new law also provides qualified immunity for several classes of health-care professionals who act according to DNR orders.

Effective date: July 9, 1998

• Physician input in pharmacists' "consult agreements"

Before your association became involved in Senate Bill 66, establishing pharmacist-patient consult agreements, pharmacists were given the authority to prescribe for your patients. The OSMA successfully removed this language, and now consult agreements must be agreed to by the physician, patient, and pharmacist, and must be patient/prescription/diagnosis specific. While the bill allows pharmacists, working within consult agreements, to modify the dosage or change the medication, the pharmacist may not change the drug that was prescribed.

Effective date: July 22, 1998

• Pain control education – our way

Doctors wanted to control their patients' pain, but misunderstandings with the medical board over how this was best accomplished left many physicians hesitant to prescribe large amounts of controlled substances. When House Bill 187, the pain-control legislation, was introduced, establishing standards for treating intractable pain, the measure mandated physicians to earn CME credit in pain management. The OSMA has policy against mandated CME and successfully removed that language. But your association is sensitive to the need for more education in the area of treating intractable pain and the OSMA is now in the process of developing a handbook

for all Ohio physicians on the subject of intractable pain and end-of-life decisions.

Effective date: Oct. 14, 1998

Despite these successes, there is still much more work to do at the Statehouse this year and next. Advanced Practice Nurses have returned with a bill that gives them prescriptive authority, and telemedicine, a statewide trauma system and mental health parity are also on the legislative docket. In order for medicine to continue to have legislative successes, your involvement is critical. Join the Ohio Medical Political Action Committee (OMPAC) and the Physician Legislative Action Network (PLAN), and stay current with new legislation and the progress of pending legislation through *Ohio Medicine* and the OSMA Web site, (www.osma.org). Remember, it's your future – and that of your patients' – that's at stake. To become involved, contact the OSMA Department of Legislation, (800) 766-6762. ■

Take Action

For a copy of the OSMA's Legislative Update 1997-98, which lists the association's wins as well as pending legislation in more detail, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580 and ask for Item #21-98.

The PHPPA Advantage

Law says plans must disclose more in contracts

The days of signing vague, unspecified contracts are almost over. With the Physician Health Plan Partnership Act, the new law that becomes effective Oct. 1, health-care plan providers will now have to disclose the following:

• All material that is referenced in the contract.

As a result of the new law, the Health Insuring Corporation (HIC) will now have to provide you with provider manuals, reimbursement information etc. prior to your signing

the contract.

- Administrative manuals related to participation, if any.
- A signed and dated copy of the final participation contract.

The law will also allow doctors to request specific information regarding the corporation's programs and procedures. This includes:

- How the participating provider is reimbursed for his or her services.

This includes the range and structure of any financial risk-sharing arrangements, a description of any incentive plans, and if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services.

- The availability of dispute resolution procedures and any costs involved with those procedures.
- How a participating provider's name and address will be used

in marketing materials.

- How referrals to other participating providers or nonparticipating providers are made.

This provision also eliminates the "gag clauses" once found in HIC contracts, Tim Maglione, director, OSMA Department of Legislation says. Now, doctors may advocate the necessary medical health-care services to patients or provide information to regulatory agencies without penalty from the MCO. ■

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What's the difference between APN and MD/DO training?

If you're looking for a way to tell legislators, your patients or people you meet why APNs should not have prescriptive authority, tell them about the educational and training differences between doctors and nurses.

On May 20, Steven Stack, MD, a then fourth-year medical student at OSU's College of Medicine and the immediate past president of OSMA's Medical Student Section, stood before members of the Ohio House Retirement and Aging Committee and presented testimony on the educational differences between Advanced Practice Nurses (APNs) and physicians. He was speaking on behalf of the OSMA – and, indirectly, at the request of the association's House of Delegates.

Just three days earlier, the House had adopted a resolution (Resolution 08-98) that calls for the OSMA, through its component societies, to educate legislators, the general public and third-party payors about the differences in training, education and qualifications between APNs and MD/DOs. Now, Dr. Stack was about to fulfill one part of that resolution.

Dr. Stack gave legislators a curriculum comparison between the training received by a family medicine physician and that of a family nurse practitioner at Wright State University in Dayton (see related chart). The material had been prepared in 1996 by another fourth-year medical student, Geoffrey Cly, then president of the OSMA-MSS, and now chair of the Resident Physician Section.

According to Dr. Stack:

- Family physicians receive, in the course of four years of medical school plus three years of residency, at least 13,560 hours of basic science and clinical contact hours. In comparison, family nurse practitioners received 275 comparable hours, a 50-fold difference.

Curriculum Comparison

Wright State University
School of Medicine & Family Nurse Practitioner Program

Course	School of Medicine		FNP Program	
	Credit Hrs.	Contact Hrs.	Credit Hrs.	Contact Hrs.
Biochemistry	11	110	-----	-----
Microbiology & Immunology	12	120	-----	-----
Pathology	22	220	(combined with physiology)	
Physiology	19	190	2	20
Pharmacology	9	90	3	30
Clinical Training	164	5,030+	22 1/2	225
Residency Training		7,800++	-----	-----
Total hours from above categories	237	13,560	27 1/2	275

+ A conservative estimate of contact hours over a 2 year period.

++ An estimate of the total contact hours during a 3 year Family Practice Residency Program.

Sources: School of Medicine: Curriculum from the Wright State University School of Medicine, Office of Student Affairs and Admissions. Family Nurse Practitioner Program: Curriculum for Master of Science Degree with a focus on Family Nurse Practitioner Course of Study, Wright State University-Miami Valley College of Nursing and Health.

Prepared by Geoffrey Cly, Wright State School of Medicine. Material based on curricula from 1995-96 academic year.

- Medical students at Wright State receive 73 credit hours in the areas of biochemistry, microbiology, immunology, pathology, physiology and pharmacology. Family nurse practitioner students receive only five credit hours of education in these areas, a 15-fold difference.

- Without thorough training in the areas listed above, a health-care provider is not prepared to understand the mechanisms of health and disease in a manner necessary to permit the safe and effective treatment of atypical disease presentations.

- One must first have a thorough understanding of how the body works before society should grant him or her the awesome privilege of prescribing

medications that alter the human body with potential not only for healing but also for grave harm.

"Based on my own personal experiences and the evidence that I have seen to date, it is my firm conviction that APNs are insufficiently trained to safely prescribe medications, which is precisely what House Bill 667 would allow them to do," he told legislators. "Allowing this increased scope of practice would be a disservice to the people of Ohio and a failure of the Legislature and medical professions to safeguard the public health." ■

Take Action

Dr. Stack's presentation needs contin-

ued support from grassroots physicians like you. While it's doubtful that much action will take place on this bill before the first of the year, it's important that you contact your legislator now. Any of the points in Dr. Stack's testimony could be used in writing a letter to your own representative. The OSMA urges all members to contact their representatives and educate them on the differences between APN and physician training. If you prefer, the OSMA Department of Legislation has prepared sample letters that you can use. Contact the department for a copy, (800) 766-6762.

Sponsor: Rep. Richard Hodges (R-Wauseon)

Rules changed for impaired physicians

The State Medical Board of Ohio has proposed new rules governing impaired physicians and other health-care professionals, including physician assistants. The rules must still be filed and undergo a hearing process.

The rules, as proposed, would:

- Mandate inpatient treatment. Impaired physicians would need to receive 28 days of inpatient treatment, including residential care.

- Mandate a minimum 90-day suspension for a first relapse. For second and third relapses, mandatory suspensions would be one and two years respectively.

- Require a 72-hour inpatient examination for all approved treatment providers, whether that is a board-mandated exam or a private referral exam.

- Impose a minimum five-year probation. The board will not consider modifications to probation in the first year.

- Redefine "relapse" to include attempts to obtain drugs for the purpose of using them.

- Clarifies that all relapses must be reported, including reporting by the relapsing practitioner.

- Allow the probationer 30 days to line up a supervising physician and a monitoring physician. Under the new rules, the probationary clock doesn't run while the practitioner is out of compliance, or when the monitoring provisions are not yet in place so any probationer who is slow to begin this process is, ultimately, delaying his or her own release from probation.

During the drafting process of these rules, the OSMA raised some concerns for the committee to consider, specifically, whether or not there are enough treatment providers available to provide the required inpatient treatment, and whether inpatient treatment will be covered by insurance or whether alternative payment arrangements will be available?

"We're also concerned by the fact that many physicians are unaware of the requirement that they must seek treatment from an approved provider, or don't know which treatment pro-

Medical Board Report

viders are approved," says Kate Hunter, OSMA legal assistant and liaison to the board. "The OSMA often gets complaints from physicians who didn't realize they should seek treatment from the approved provider. More importantly," she adds, "the treatment providers themselves are often unaware of the necessity to obtain board approval." This may be especially true if the treatment provider is well-known but out of state.

Ed Poczekaj, director of Field Services for the Ohio Physician Effectiveness Program (OPEP), an agency that focuses on helping impaired professionals, says that legislating treatment for a disease and consequences for failure to maintain remission will always be prone to debate. "We have regulatory and clinical agendas in complicated interaction," he says. "These agendas are influenced by job roles, divergent professional opinions, conflicting studies, public opinion and personal experience and belief."

However, the relapse rules, according to Poczekaj, appear to address both regulatory and clinical perspectives. Relapse seems to be recognized as a potential part of the remission process. The public is protected by varying lengths of suspension, and the physician has the ability to re-establish recovery, demonstrate stability and avoid revocation of his or her license. "Overall, the relapse rules seem consistent with clinical principles," he says, with the exception of the mandatory loss of a DEA in a relapse consent agreement, especially where there is no criminality. "That appears as a clinical departure and relapse into the moral model of punitive thinking," says Poczekaj.

Consideration of no board sanction in favorable relapse cases, where a physician immediately self-reports and where there is no related past or pre-

sent patient harm, seems to demonstrate a growing clinical understanding of relapse and an enlightened regulatory approach to this difficult issue, he continues. "The public must be protected but impaired physicians needing help must also be encouraged to seek that help without undue fear of regulatory and occupational consequences."

Ohio Medicine will notify you when the rules have been adopted, and will make those available through our Ohio Medicine reader response line.

Of note...

Rules filed, rules held...Because of the "voluminous" testimony provided at the hearing on the board's proposed weight loss rules, those rules are still under discussion at the committee level of the board. No further action has been taken. Meanwhile, rules on the board's staggered continuing medical education (CME) schedule, as well as other CME-related issues have been approved by the board. If you would like to order a copy of the CME rules, as filed by the board, see the information under the "Take Action" headline below.

Alternative medicine discussed...A recommendation to change the name of the board's Limited Branch Committee to the Alternative Medical Committee triggered some discussion on the subject of alternative therapies and whether or not these should be regulated by the board. One board member raised the subject of whether or not nonphysicians should be licensed for acupuncture procedures the way they are in Minnesota and California. Other alternative forms, such as hypnosis, herbal medicine and arurvedic, have their own practitioners and may need to be licensed as well.

Self-prescribing questioned...Some pharmacists are so cautious of doctors who prescribe for themselves that they are hesitant to fill prescriptions, even for noncontrolled medications. The Pharmacy Board is alerting pharmacists through its newsletter that doctors may prescribe such substances for themselves if the physicians undertake the medical board's precautions.

Have your PA utilization plan ready...The board's Quality Assurance

Committee discussed the fact that audits of physician assistant utilization plans are turning up instances where the physician is not aware of the utilization plan's provisions and, in some cases, can't locate the utilization plan itself. The committee urges physicians who use PAs to have their plans available for inspection and to review these plans, themselves, on occasion.

Position paper on delegating medical tasks OK'd...Physicians who have unlicensed personnel in their offices may wish to send for a copy of the board's new position paper on the "Delegation of Medical Tasks." The paper provides guidance to those medical practitioners who must make decisions concerning what kinds of tasks can be delegated, and to whom. To order a copy for your office, see the information under the "Take Action" item below.

Take Action

To order copies of the board's final CME rules or its new position paper on the Delegation of Medical Tasks, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580 and ask for item #22-98 (CME rules) and/or item #23-98 (position paper).

Who should use lasers?

As Ohio Medicine reported to you last month, the State Medical Board of Ohio's Minimal Standards Committee is considering promulgating rules on who may be authorized to use lasers and are turning to 30 states with rules on laser use to see how those have been drafted.

The OSMA would like your opinion. Send your comments to: OSMA Division of Legal Affairs, 3401 Mill Run Drive, Hilliard, OH 43026, e-mail: legal@osma.org. You may also comment on the OSMA's Web site Bulletin Board, www.osma.org

Dateline Ohio

Direct Physician Care of Ohio decides to liquidate

Following a feasibility study, a group of Northeastern Ohio physicians decided against forming a physician-owned managed-care organization.

An attempt by a group of about 12 Northeast Ohio physicians to form a physician-owned and controlled managed-care organization in Ohio has fizzled. Direct Physician Care of Ohio (DPCO) learned from a feasibility study, conducted by Michigan Medical Advantage, that two options were available to the group – a

risk-bearing IPA or PPO, and, according to Deodutt Patel, MD, DPCO president, “the unity of physicians was not there” to support either option.

All DPCO contributors were advised in June of the company's liquidation and were presented with three options for disposing of remaining DPCO funds.

In the feasibility study, the consultants learned that:

- A health plan owned by physicians doesn't appear to be an important positive factor for most employers in their choice of a health plan.

- Only one-third of employers view

an endorsement by the OSMA as important in their choice of a plan.

- Nearly two-thirds of employer representatives interviewed felt a statewide network of physicians isn't important.

The report also pointed out that seven medical societies, in states with significant managed-care penetration, have either established or endorsed physician-owned health plans over the past few years but, none of the four physician-owned plans established by a state medical society has been successful. One of the plans has been sold, one will become a physician network, and two do not have enough covered lives to be competitive.

“It's discouraging when the group that mentored you doesn't have the right management, and it folds,” says Dr. Patel. “There isn't much incentive to continue.”

He says he has been discouraged, too, by “physician apathy” in Ohio toward a statewide physician-owned and controlled MCO. “The attitude seems to be (the network idea) is too little too late, so let's not even try,” says Dr. Patel. “There is no thought to the future in a global sense. Physicians complain constantly but they don't see the benefits of a united front.”

Dr. Patel is not unhappy that he made the effort to try to get the project off the ground. “When you put as much time and effort into a project like this – you want to preserve it, in case the embers may ignite at some point in the future.”

If anyone is interested in launching a similar undertaking, Dr. Patel says he will be happy to help, and he hopes, in the future, someone will want to take on this project – “for the benefit of a future generation of physicians.” ■

Dayton area hospitals get OK to restock

Dayton area hospitals are free to continue a long-standing practice of restocking ambulances without fear of violating the federal anti-kickback law.

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services approved the Greater Dayton Area Hospital Association's plan to restock ambulances and distinguished it from the northern Kentucky ambulance restocking practice that drew the OIG's attention last fall. The OIG's notice of a possible violation in Kentucky caused hospitals nationwide to reconsider, revise and even discontinue ambulance restocking practices.

The OIG commented that the greater Dayton program:

- does not increase the risk of over-utilization and is unlikely to lead to increased costs for federal health-care programs;
- is part of a comprehensive and coordinated regional effort to improve all aspects of emergency medical services, and;
- is likely to have a positive impact on the quality of patient care.

A critical factor in the OIG opinion was the local emergency medical services council's control over the restocking program.

“This significant community benefit, coupled with the conditions, requirements and limitations outlined above, persuade us that the arrangement poses minimal risk of fraud and abuse under the anti-kickback statute, and therefore the OIG would not subject it to sanction,” the opinion says.

Although the opinion is binding only for the greater Dayton hospitals, it could be used to help other hospitals across the state and the nation to assess the legality of their own restocking practices, says the OIG. — Kaci Brown

October 2, 1998

SPEAKERS:

world renowned sleep specialists:

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Howard P. Roffwarg, M.D.
Richard Ferber, M.D.
Shahrokh Javaheri, M.D.
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Markus H. Schmidt, M.D., Ph.D.

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KEYNOTE
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Randall admits to taking bribes

David Randall, former deputy director of the Ohio Department of Insurance, agreed to plead guilty to two counts of bribery and one count of falsification, stemming from his involvement with former Statehouse lobbyist Thomas S. Strussion and the PIE Mutual Insurance Company founder and former Chief Executive Larry E. Rogers.

The second-ranking official at the department from March 1991 to April 1997, Randall admitted he accepted a variety of gifts from Strussion ranging from luxury box tickets to Cleveland Indians games to the use of Rogers' Hilton Head, S.C., vacation home.

Randall admitted that Strussion also paid for part of his wedding reception.

Randall's charges are third-degree felonies which carry a maximum penalty of five years in prison on each count.

In addition, the ODI filed suit in July against 12 former PIE employees, seeking to recover \$1.3 million in alleged improper payments. ■

Civil War buffs can attend event for free

The Ohio Historical Society (OHS) will set aside a weekend in September for physicians, surgeons and general visitors interested in Civil War medicine.

Members of the Society of Civil War surgeons will meet Sept. 12-13 in the OHS's Ohio Village in Columbus to offer demonstrations on 19th-century medicine – both on the battlefield and at home – to visitors.

Physicians who offer professional identification will be admitted free during the event.

For more details, contact the Ohio Historical Society, (614) 297-2300. ■

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Anthem's repayment demands trigger quick response from OSMA

Some physicians who contract with Anthem Blue Cross and Blue Shield are angry about letters they received from the insurer, requesting them to repay overpayments they received from Anthem during a period from April 1996 to November 1997. According to Anthem's letter, during this period, Anthem's claims processing system reimbursed certain managed-care claims at the advertised plan fee schedule instead of the managed-care fee schedule.

According to reports received by the OSMA's Department of Ombudsman Services, the initial letter was sent June 22, requesting payments anywhere from \$300 to \$3,100 (higher for some groups). Anthem told the physicians the repayment must be made within 30 days of receipt of the letter. Then, in mid-July, these same physicians received a second letter from the insurer (with the same June 22 date) giving the physicians a new amount to pay. "In many cases,"

says Bill Fry, director of OSMA's Ombudsman Services, "the overpayment against the doctor doubled."

OSMA responds

In response, OSMA President Lance Talmage, MD, fired off a letter to Anthem's executive director of health services stating: "Anthem is contractually qualified to seek overpayment recovery. However, to do so after two years since payment causes an unreasonable burden on physician office systems, their income tax filing requirements, and necessary time for office billing staff to reconcile the individual accounts. These errors by Anthem should have been identified six months after payment, or at least no more than 12 months."

Dr. Talmage pointed out that Anthem was in error and their correspondence to physicians should have expressed some apology for the grave inconvenience this event has caused. The OSMA believes

that, since Anthem did not discover its error until years later, simple fairness would dictate that the carrier would not require physicians to reimburse the overpayment.

Coming trend?

A similar situation was reported in the April 1998 issue of *Action*, a newsletter published by the Texas Medical Association. Bradley Reiner, TMA's manager of payer relations, said he has received numerous calls on overpayment issues. "Sometimes, it has been several years since the physician submitted the claims and was paid for it." And in most cases, he adds, the overpayments were the insurance company's mistake. "This is a trend in the health-care insurance industry," he continues. Insurance companies (and self-insured employers, adds Fry), hoping to recoup money, hire auditors to examine past-paid claims. These auditors look to see if the patient was el-

igible for the service, had terminated from the plan or had a pre-existing condition, or if the service was medically necessary, and if the claim was paid the correct amount.

"In the case of Anthem, the auditors apparently found that the wrong payment schedule had been used," says Fry.

Your legal obligations

Are you legally required to repay the overpayment?

"Check your contract," says Katrina English, JD, director of OSMA's Division of Legal Affairs. If your contract doesn't include any provisions about overpayment then you may have a case for not repaying the amount. If a provision is there, you may wish to consult your attorney before determining how to proceed with the requests for repayment.

The OSMA will continue to monitor this situation and *Ohio Medicine* will bring you developments as they occur. ■

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8:00 a.m. - 5:00 p.m.

George S. Dively Building
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- ▶ Depression Across the Life Cycle
- ▶ Cardiovascular Risk Factors
- ▶ Cancer Screening Guidelines for Women
- ▶ Sexual Issues in the Mature Woman
- ▶ Urology - Not For Men Only
- ▶ Health Across the Feminine Life Cycle
- ▶ Type II Diabetes
- ▶ Elder Abuse and Neglect

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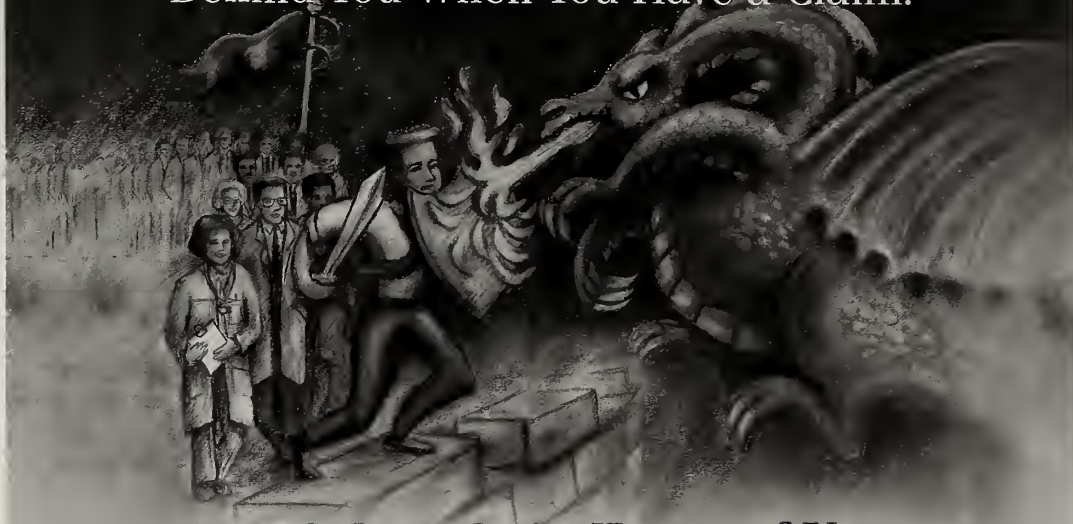
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Indepth Report

Why one physician didn't renew her Aetna contract

Physicians have been traditionally passive when presented with managed-care contracts. But recently, Cincinnati gynecologist Molly Katz, MD, received a wake-up call when she realized the negative impact that a specific contract would have on patient care.

In particular, a number of aspects of the new Aetna/US Healthcare contract were objectionable – and evidently not negotiable. Of particular concern were changes in covered services, referral procedures and documentation requirements; they imposed restrictions on doctors and patients.

"The time is overdue for every single practitioner to review every managed-care contract from the perspective of patient care," says Dr. Katz.



Molly Katz, MD

What's the problem?

Some of the new policies are costly and inconvenient, others have even deeper implications.

"Many women consider their ob/gyn to be their primary care physician. Just yesterday morning, two of my first four patients had been self-referred to us for depression. One had met her primary care physician; one had not. They both preferred to see me about this particular problem. Under the new Aetna contract, these visits would have to be treated at out-of-network cost to the patient, which may discourage patients from seeking help at all.

"Right now, we have a dynamic

generation of women who are assuming responsibility for their own care decisions. A physician should not tell these women which imaging center to attend, nor make appointments for them. And most particularly, that type of decision should not be made for them by an insurer. That would be taking a huge step backward.

"Even if it weren't condescending, and women would stand for it, the time and coordination required for such communication between the physician's office and the patient would be unreasonable," Dr. Katz continues.

Dr. Katz had numerous other examples of policies that she believed reflected lack of thought and perspective. "Filling out and copying the new five-page mammography form at our expense (time and money) is simply impractical and unreasonable. Using codes unique to Aetna and not always compatible with existing accounting systems is also unreasonable. Drawing blood requiring a phlebotomist's time and filling out the related paperwork are not reimbursed by Aetna unless the patient makes a second office visit to the office for that specific service."

Other issues

"Even though more than 20 Cincinnati-area ob/gyns have chosen not to renew their Aetna contracts, this has not been a group decision," Dr. Katz continues. "Specialty-practice physicians had discussed the changes informally, but we all decided that each practice needed to assume responsibility for its own decision and actions. These decisions were made strictly as individual practitioners.

"In January, about 30 ob/gyns and several primary care physicians attend-

ed an Aetna information meeting about Aetna's new women's health policies booklet. We were left with the distinct impression that the contract was not open for discussion, nor negotiable."

"My own group turned to OSMa for a contract evaluation since it is our industry specialist and advocate. Also, seeking private legal opinions on all of our contracts wouldn't be economically feasible.

"OSMA confirmed that some of the Aetna contract conditions were onerous and, in February, we decided not to renew, based on several new Aetna policies.

"From a financial viewpoint, the decision would affect about 700 or 10% of our patients, which, we believed, was probably the fewest we would ever have that were covered by Aetna. Besides, our practice isn't driven by our accountant.

"This is not a reimbursement issue. The issue is that we care for every patient and that care should not be influenced by their choice of an insurer. With Aetna's unique requirements, we would have to plan each office visit with the insurer in mind, from check-in to unique coding at check-out."

Informing the patients

A patient letter was mailed in early February informing them that the decision would take effect in early May. The letter offered to assist each patient with the selection of a new physician, and to try to make other financial arrangements if the patient chose to continue to see Dr. Katz's group.

The letter specifically listed those Aetna plans that were affected. And, "If they (Aetna) allow us to participate

Terminating a patient relationship

If you choose to withdraw from a patient's care because you don't intend to renew your contract with a plan, the patient must be given reasonable notice so that he or she may seek alternative medical care. Your provider contract may require you to follow certain procedures in lieu of the following:

1.) Evaluate the patient's condition and render any necessary care to stabilize the patient.

2.) Inform the patient of his/her illness and emphasize the need for follow-up care. (The physician may refer the patient to another physician.)

3.) Notify the patient of the intent to withdraw care by a definite date, allowing sufficient time for the patient to obtain alternative care (notice of 14 to 30 days is usually sufficient.) A reason for termination is not necessary.

4.) Inform the patient that emergency care will be provided in the interim.

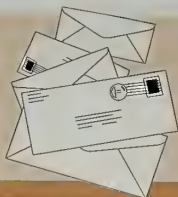
5.) Inform the patient that records will be made available to the new physician upon receipt of the patient's written authorization.

6.) Document steps 2-5 in writing by registered letter with a return receipt requested. A copy of the letter and the return receipt should then be kept in the patient's file.

The nature of the relationship may dictate the manner and terms of termination. If reasonable notice is not given and the patient suffers damages as a result, the physician may be liable for abandonment. Once the relationship is terminated, the physician is under no obligation to follow the patient's progress.

(This information is from the OSMa Fact Sheet "Termination of the Physician/Patient Relationship.")

continued on page 18



Letters

More methods to prevent unplanned pregnancy

To the Editor:

In response to your Public Health article on "Preventing Unplanned Pregnancy" (June 1998), I agree that we all can do a better job of addressing unplanned pregnancies and being more proactive on this topic.

However, I do take issue with the blatant absence of the two most important methods of prevention – specifically those of abstinence and natural family planning. They are the two safest and are wonderfully effective. They also help strengthen relationships.

Let's not write these off.

Thaddeus M. Bort, MD
Cincinnati

Moving?

If you are a physician and have recently moved or are planning on moving, please notify the OSMA of your change of address so that you won't miss an issue of *Ohio Medicine*.

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OSMA News

The danger of apathy

"It is necessary only for the good man to do nothing for evil to triumph."

Edmund Burke, 1729-1797
Irish-born Whig politician

Apathy may be the greatest curse of today's society and it is insidiously working its way into our profession. I see its approach on three fronts.

First, I see it with young physicians who are content to go into practice, attentive to clinical procedures but oblivious to all of the administrative details that are as much a part of medicine as treating patients. These young doctors – and some who have been in practice for a while – are content to let others handle the paperwork and provide coding for procedures that are, in fact, their responsibility. This is where real expertise is needed. We need to become familiar (if we aren't already) with the codes and forms which govern our reimbursement. Unintended mistakes give the Health Care Financing Administration (HCFA) ammunition to accuse physicians of fraudulent billing. We don't want hassles so we must take part in



Lance Tolmage, MD

President's Perspectives

assuring accuracy.

Second, I believe there is apathy about organized medicine. Too often, I have heard doctors say that, even if they don't become members of organized medicine, they will still reap the benefits. Legislation that is passed in medicine's favor (or bad legislation which organized medicine deters) is a major benefit from both the OSMA and the AMA. However, organized medicine can't continue to serve effectively at the Statehouse – for members or nonmembers – if the funding from dues isn't there to support our efforts. Money we collect from dues allows us to hire the kind of quality people we need to assist in gathering the research we need to support or oppose a bill, to educate legislators on the issue, and to monitor the bill throughout its legislative hearings. We must also keep our membership informed of issues to assure their ability to practice quality medicine. The challenge to us is to convince physicians to read about the problems before they are faced with a crisis.



Finally, I see a level of physician apathy at the community level. It's true that both our practices and families have a legitimate claim on our time, but as a result, physicians are spending less time in volunteer services in their communities. Charity boards and service organizations are in need of physicians who can lend their skills, talents and expertise – not as members of the profession, necessarily, but as members of the human race. When we don't show up, we give the community the false impression that we don't care. The appearance of affluence without an accompanying contribution back to the community engenders envy. Suddenly, our public image goes from "warm and compassionate" to "hands-off and elitist."

It doesn't take much to dispel apathy. All you need to do is roll up your sleeves and pitch in – whether that means deciphering the mysteries of coding, signing on as a member of your county medical society or volunteering for an open position on this year's board of United Way.

The physicians in Ohio are good at quality patient care. They must also become fired up and shake off their apathy. Our medical system will fail us and our patients unless we defend and protect it. Our leaders are selected because they care and are willing to use their time and energy for the good of all. Overcome the lethargy. Openly participate and support the efforts of your chosen leaders. And bring along a friend. ■

Pain handbook mails next month

A handbook for managing pain will be mailed to all Ohio physicians next month, courtesy of the Ohio State Medical Association.

The handbook was developed by the OSMA's ad hoc committee on pain education, chaired by Jay Williamson, MD, Rootstown and edited by Robert Gillette, MD, Poland.

Drs. Warren Wheeler, Columbus; Constantino Benedetti, Columbus; and David Dawdy, Westerville served as consultants on the project. Contributing writers were: Eric M. Chevlen, MD, Youngstown; Mark Boswell, MD, PhD, Cleveland; Thomas Vetter, MD, Akron; and Bill Bauer, MD, Bellevue.

The need for a handbook on pain management grew out of legislative negotiations to drop mandated pain management continuing medical education (CME) from a bill on pain control that passed last year. Completion of the handbook was predicated on the completion of the State Medical Board of Ohio's rules on managing chronic pain. Those rules have been filed, clearing the way for the handbooks to be mailed.

The handbook offers recommendations for treating a variety of chronic pain situations, including cancer. There is no charge for the book, and CME credit is available for physicians who complete the handbook. ■

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County Medical Society News

Stark County Alliance wins national award

The Stark County Medical Society Alliance received the 1998 Health Awareness Promotion (HAP) award for fund-raising for its "Casino Royale" event which raised funds for AMA-ERF scholarships.

Guylase Ergun, who initiated and orchestrated the event, presented highlights of the project at the American Medical Association Alliance House of Delegates Annual Session in Chicago in June.

In 1989, the AMA Alliance began the HAP award to recognize excellence in health promotion programs and projects of alliances throughout the nation.

CMA elects new officers

The Columbus Medical Association and Foundation have elected new officers for the 1998-99 year.

The association named Richard Nelson, MD, president and Steven Richardson, MD, as president-elect. Gregory Gibbons, MD, is the new secretary-treasurer and Alice Epitropoulos, MD, will hold the office of secretary-treasurer-elect.

Immediate past president Michael Mishkind, MD, and the new officers will comprise the CMA Executive Committee and also serve as board trustees for the CMA Foundation.

In addition to the new association officers, the Columbus Medical Association Foundation has elected Teresa Long, MD, as new board president and re-elected Gerald Penn, MD, and Claire Wolfe, MD, to the position of vice-president and secretary-treasurer respectively.

Charles Hickey, MD, will continue to serve as CMA Foundation board trustee and CMA Alliance president Sue Dingle has been appointed to serve as CMA foundation board trustee. —

Kaci Brown

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Fact sheets answer commonly asked legal questions

What are your responsibilities under the Americans with Disabilities Act? What employment laws are you required to post? What do you need to know about closing your practice before you retire?

The OSMA provides you with this information and more, not only through the *Physician's Guide to Ohio Law*, but also through a set of legal fact sheets that touch on the topics listed above, as well as many others.

The fact sheets are intended to respond to the questions that are most commonly received by the OSMA's Division of Legal Affairs, and they provide you with an excellent resource to turn to when you're confronted with one of those practice management or other issues that surface in your practice day to day.

Topics include:

- Billing and collection practices
- Driving impairment
- Duty to report
- Informed consent
- Waiving co-payments and deductibles and
- Terminating the physician-patient relationship.

Copies of the fact sheets are now available on the OSMA Web site, www.osma.org. To locate them on the site, go to the "Hot News" section and click on Legal Fact Sheets. You may download these fact sheets to keep in your files. ■

"Hospice of Dayton is the standard for terminal care in the area." (Area Family Practice Physician)

Hospice of Dayton makes a difference for your terminally ill patients and their families.

Patients and families in our Hospice of Dayton programs frequently lament they didn't come to us earlier in the course of their illness. Consistently, we hear from families: "I just wish our doctor would have mentioned hospice care sooner." When a patient comes to us close to death, we can't provide the full scope of our services. Hospice of Dayton's team of professionals can provide palliative care to the patient and emotional and spiritual support to both the patient and the family. When cure is no longer an option, suggest hospice care to your patients.



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OSMA awards 4-H youth leaders. Each year, the OSMA becomes involved in youth leadership through the 4-H Health Day of the Ohio State Fair. At last year's fair, Korrino English (far right), director of the Division of Legal Affairs, presented the junior award to two 4-H youths whose project covered the health dangers of smoking.



CHARLES D. ARING, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1930; age 93; died April 15, 1998.

MURRAY M. BETT, MD, Canton, Faculty of Medicine University of Edinburgh, Edinburgh, Scotland, 1951; age 69; died April 1, 1998.

PATRICK B. CESTONE, MD, Youngstown, St. Louis University School of Medicine, St. Louis, 1943; age 80; died April 23, 1998.

HENRY FELSON, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1932; age 91; died March 9, 1998.

THOMAS M. FILE, MD, Dayton, St. Louis University School of Medicine, St. Louis, 1956; age 67; died April 25, 1998.

ROBERT T. GRAY, MD, Prospect, Ohio State University College of Medicine, Columbus, Ohio, 1936; age 86; died April 15, 1998.

CHARLES E. HOLZER, JR, MD, Gallipolis, Cornell University Medical College, New York City, 1941; age 81; died Feb. 12, 1998.

WILLIAM HUNTING, MD, Florida, University of Cincinnati College of Medicine, Cincinnati, 1938; age 87; died April 8, 1998.

RICHARD JUST, MD, Ravenna, Ohio State University College of Medicine, Columbus, Ohio, 1984; age 43; died March 24, 1998.

Obituaries

DONALD H. MAC PHERSON, MD, Marion, Tufts University School of Medicine, Boston, 1945; age 80; died April 3, 1998.

JOHN MCDONOUGH, MD, Youngstown, Loyola University Stritch School of Medicine, Maywood, Ill., 1937; age 89; died March 28, 1998.

THOMAS ELMER OGDEN, MD, Dennison, Ohio State University College of Medicine, Columbus, Ohio, 1955; age 69; died March 4, 1998.

BENJAMIN M. SPOCK, MD, Camden, Maine, Columbia University College of Physicians & Surgeons, New York City, 1929, age 94; died March 16, 1998.

FRED R. TINGWALD, MD, Cleveland, University of Iowa College of Medicine, Iowa City, Iowa, 1938; age 83; died March 18, 1998.

CLINTON W. TROFT, MD, Centerville, Loma Linda University School of Medicine, Los Angeles, 1941; age 81; died March 24, 1998.

JAMES ZULLIGER, MD, Lima, Ohio State University College of Medicine, Columbus, Ohio 1945; age 76; died April 25, 1998.

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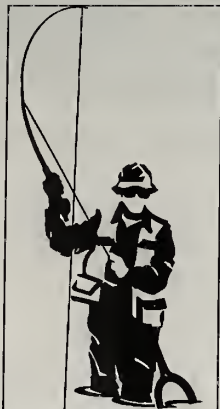
OSMA Profile

A demographic look at your association.

Gone fishin'

More physicians are retiring than ever before, and at younger ages. (Don't let the *Gone Fishin'* title fool you. Many of these members are involved in numerous activities in their retirement.) The youngest retired OSMA member is 45 years old and there are six retired physicians who are 100 years or more. The total number of retired physicians in the OSMA is 2,944. Here are the statistics:

Age group:	# of retired:
40-49 years	5
50-59 years	70
60-69 years	614
70-79 years	1,373
80-89 years	727
90-99 years	149
100 or more	6



Source: OSMA Electronic Data Processing Department

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Aetna... continued from page 12

in select plans, such as the PPO, we with the selection of a new physician, and to try to make other financial arrangement if the patient chose to continue to see Dr. Katz's group.

The letter specifically listed those Aetna plans that were affected. And, "If they (Aetna) allow us to participate in select plans, such as the PPO, we will be happy to renegotiate our contracts with them."

The letter concluded strongly, with the main point: "It is only if we continue to monitor quality of care and exercise our right to contract, that we will encourage managed care to work for all of us."

Patients 100% favorable

"Patient response has been incredibly supportive, with a number of patients expressing that they, too, have experienced communication problems with Aetna. We've received supportive letters from patients who are both in and out of the plan.

"Many patients have discussed the issue with friends, who have since become referrals. In the past, most patients were probably unaware of the language in their managed-care policy book; now, some have gone to their employers' plan administrators with complaints. Patients must have gone to the media about the issues because, to my knowledge, physicians didn't. The whole issue has taken a life of its own, without instigation by myself or any other physician.

"We've copied the Aetna provider list, with recommendations highlighted, for about a dozen people, although lists are rarely current.

"Not renewing our Aetna contract did create some scheduling openings, so we called our cancellation list, who were very glad to get in sooner than expected. We haven't experienced downtime at all.

"Although we hadn't planned a marketing campaign, we did add a fourth partner in May, so some new promotion is occurring."

Advice to others

Since February, Aetna has raised their reimbursements, but that misses the point, says Dr. Katz.

She would "like to see other doctors

realize that we can turn down contracts, that we don't have to accept every one that's offered. And, if this furor makes patients read their contracts, then I will have achieved something."

Dr. Katz doesn't expect physicians to form their own managed-care systems. A local program on the topic was canceled for lack of response. "Physicians aren't interested in being in the insurance business, and forming such an organization requires immense resources," says Dr. Katz.

"Ideally, but I realize, unrealistically, we would like to solely practice medicine. In fact, I think our unfamiliarity with contracts and the business of health care is partially responsible for our situation now.

"Patients are already paying for their own health-care coverage, in one way or another, and may have to contribute more in the future. They should take advantage of any opportunity to participate in the care they are receiving by evaluating their insurer contracts, just as we physicians need to be evaluating what we agree to with those same insurers." ■

Take Action

OSMA offers a contract review service. If you would like a copy of the review of the Aetna/US Healthcare contract, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #24-98. Specify whether you need the specialty, group or primary contract. The OSMA Division of Legal Affairs also has on information packet for members who may have concerns with their Aetna contracts. To order a packet, call and ask for item #25-98.

Star recruiters

Six OSMA members helped the AMA add a record 3,953 new members this year.

The AMA recognized the following "star recruiters": Louis Goorey, MD; Charles Hickey, MD; Stephen House, MD; Elizabeth Jennison, MD; Edmund Jones, MD; Daniel Van Heeckeren, MD.

Practice Tips

How to collect your money and still keep your patients

You're concerned, naturally, with providing quality health care for your patients, but in order for your medical practice to stay in business you need to be concerned, as well, with the cash flow coming into your office. And that means, sooner or later, you need to be concerned about billing and collection practices. The OSMa has prepared a legal fact sheet on this topic for its members. (To order a copy, see the "Take Action" item below.) The information on collection procedures presented here comes from this member benefit.

Most of your patients can and will pay their bills properly and promptly, but if they don't, you need to make a consistent effort to collect your fees from these patients. In some cases, you may even be required to do so by the plan that has contracted your services. (See related story in Contract Issues, page 20.) If you're reluctant to play the role of collector, you should know that it usually takes little extra effort to collect the majority of overdue bills and that not collecting unpaid debt is unfair to your paying patients.

Steps you should take

To collect debts from unpaid accounts, your office should:

1. **Prepare a collection timetable.** Obviously, you should have a sufficient billing system in place as well as someone in your office who is efficient at filing and processing insurance claims. Yet equally important is a follow-up policy for overdue bills. The OSMa suggests that you have in place a "collection timetable" to determine what collection steps are taken and when. A timetable should include:

- Sending a billing statement.
- Sending a letter reminding the pa-

tient that the bill is due.

- Calling the patient to secure a commitment of payment, to arrange a payment plan, or to determine if the patient is able to pay or won't pay because of dissatisfaction with the care received.

- Sending a second letter reminding the patient that payment has not been received.

- Sending a final reminder letter and making another follow-up call if needed and

- Finally, turning the account over to a collection agency, if the payment is still not received and there is no known problem.

2. **Use an "accounts receivable aging record."** Once your timetable has been established, using an aging record accomplishes several things. First, it provides you with a patient-by-patient listing of those accounts which require collection follow up; second, it provides you with an overall picture of the collection system's effectiveness and finally, the record will give you an estimate of the real worth of the accounts receivable.

3. **Select a collection agency carefully.** If you want to use the services of a professional collection agency, select carefully. The service will act as your representative, so be sure the procedures and techniques used in collection conform with the ethics and dignity of your practice and the medical profession as a whole. (OSMA endorses IC System which manages accounts receivable and collects on unpaid bills. Contact the company at (800) 685-0595.) Insist on having the final say on the disposition of any patient's account. Turn all necessary information over to the agency, and cease all billing on that account. Phone calls from patients to discuss the bill

should, at this point, be referred politely to the agency. If payment from the patient arrives at your office, that should be reported to the agency. Expect to pay the collection agency you hire for its services as well as a portion of any payment made on an account that has been turned over to it. If you find the agency has been successful in collecting payments, you might consider that your office isn't doing all it can to secure payments. Review your collection timetable.

Collecting don'ts:

- Never threaten a patient with the statement you will turn over the bill to a collector if you have no intention of doing so. This violates the federal Fair Debt Collection Practice Act. To comply with this law, you should also:

- Never call a patient late at night or at work if you know personal calls are not permitted;

- Don't let a third party know you're attempting to collect a debt from the patient;

- Don't send overdue notices on postcards or send statements with "Past Due" marked on the outside of the envelope.

- Don't refuse patients access to their medical records because of unpaid bills. The AMA's Council on Ethical and Judicial Affairs considers this improper behavior. ■

Take Action

If you would like a copy of the OSMa Legal Fact Sheet on Billing and Collection Practices, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580 and ask for Item #26-98.

Medicaid won't accept folded claims

The Medicaid offices of the Ohio Department of Human Services will no longer accept hard copy claims that are folded. If you do not submit the claims yourself, you should notify the office staff member(s) in your practice who are responsible for submitting Medicaid claims. All Medicaid claims should now be mailed flat in envelopes that measure at least 9x12 inches in size. All claims that are not submitted in this manner will be returned to the sender.

According to Medicaid officials, folded claims must be opened manually and they require special handling to process — all of which delays your reimbursement. In addition, in order to ensure proper microfilming of the claims, they must be free of paper folds and creases.

The department continues to encourage electronic filing of claims. If you are currently submitting hard copy claims and would like information on electronic media claims submission, contact the department's Provider Relations staff at 1-950-5267, then 8-3288. This is a toll-free number, but it does not require the "800" prefix. ■

Don't miss out

Have you visited the OSMa's Web site lately? If not, you may be missing the latest news. The site is updated every Tuesday and Friday.

Visit often for the latest Ohio health-care news.

www.osma.org

How to create successful physician networks

Thomas Wolff, JD, manager of Physician Network and Contracting Services for Michigan Medical Advantage, presented case studies of two physician networks to members of the OSMA's Organized Medical Staff Section (OMSS) at the section's Annual Meeting, held in May in Cleveland. He looked at both a physician organization (PO) and a single-specialty network (SSPN) and identified for OMSS members the key elements of a successful network. These include:

• Sound strategy

Research the marketplace, he says. Determine who the employers/payers are in your area. Then, use that research to strategize a business process. Develop goals, a mission or vision statement, your business strategies and an action plan. No matter what type of network you want to create, sound strategy must be part of its underlying function.

• Strong physician leadership

Physicians who assume a leadership role in a physician network must be willing to accept the need to change. They should also recognize the potential of physician-driven strategy. In addition, physician leaders need to be respected clinically, and should have:

- 1.) good business sense;
- 2.) managed care experience;
- 3.) strong organizational skills;
- 4.) excellent interpersonal skills;
- 5.) a willingness to devote the time and energy to creating the network and keeping it operational.

• Independent advisers and administrators

"These are important," says Wolff. "Physicians need professional advisers such as business and legal consultants to help them form their PO or SSPN." Physicians also need capable administrative support to handle the day-to-day operations of the network. He cautions, however, against using hospital personnel to staff the network. You need your own staff, loyal to you.

• Effective governance

Networks should be run as businesses, not democracies, says Wolff. "Your leaders should be empowered to make decisions." He advises that governing boards be

kept small, but that leaders must be sensitive to the needs of the members of the network, and these leaders should work hard to keep all members well-informed of decisions and other business.

• Adequate capitalization

Capital will be needed for those independent advisers and administrators mentioned earlier, as well as for office space and an information system. Sources of capital may include physicians, loans, or another entity that has a similar strategic vision. Wolff says that a nominal investment by physicians is typical, but successful networks often require a significant buy-in investment from the physician. Otherwise, the network is too often under-capitalized.

• Effective QA and UM mechanisms

Physicians are becoming increasingly comfortable with Quality Assurance and Utilization Management practices, says Wolff. It is especially helpful if the physician has provided input in developing the QA/UM guidelines for the network. "The medical director plays a key role here," says Wolff. He or she will help resolve disputes and to educate physicians on practice parameters, length-of-stay guidelines and other mechanisms established by the network.

• Reliable data

Like a sound strategy, reliable data is the foundation of your network. Wolff suggests that you have your network generate its own data to see how you're doing.

As far as gathering members for your network, Wolff says to begin with a small group of compatible physicians. "Be selective in choosing members to join," he says. Members need to be committed to the network, so they need to be able to embrace the concept of managed care, and have a similar vision of how they will manage managed care. ■

Take Action

For audiotape copies of Thomas Wolff's presentation and the other presenters at the Organized Medical Staff Section's Annual Meeting, contact Shar Wackman, (800) 766-6762, Ext. 6773. Cost for the tapes is \$11.50.

Contract issues

Copays, deductibles: Collecting for the plan

Suppose a managed-care plan wants you to sign a contract which requires you to collect copayments and deductibles from patients. What's the harm in that?

That depends on the contract's provisions.

First, be certain you have a clear understanding of the amount that is to be collected. Is this amount consistent with all patients in the plan or does it vary? If it varies, how will you know the appropriate amount to collect from a patient at the time of the patient's visit?

Also, determine with the plan whether or not you will be able to collect copayment amounts at the time of the appointment. If the managed-care organization must determine the deductible amount, you won't be able to collect the patient's fee at the time of service. Billing for the copayment after the patient's visit may not be worth your time, but if you're required to do so under the terms of the contract, you have no choice so be sure that you clearly understand what your obligations are.

If you see these provisions in con-

tracts, protect yourself by:

• **Evaluating the burden** that will be placed on your office staff if you must comply with collection procedures outlined by the MSO. Keep in mind, also, that some patients will not fulfill their financial obligations to you.

• **Asking if the managed-care plan will provide assistance** in collecting copays. Most contracts, however, will not require the plan to provide this kind of assistance.

Before you sign a contract with a

provision that requires collections, be fully aware of what you're signing on to do, then be prepared to do it if you sign. ■

Take Action

The OSMA Division of Legal Affairs offers members a contract review service. For more information, contact Kate Hunter, (800) 766-6762, Ext. 6766.

(For more information about your rights and responsibilities in collecting fees, see the story on page 19.)

Nominations taken for award

If you know a physician who is an OSMMA member, under the age of 40, and who has displayed outstanding service to his or her profession, community or to organized medicine, *Ohio Medicine* would like to hear from you.

Please send in the name, address, and phone number of the physician you would like to nominate for the "Young Physician Award" and briefly explain the reasons for nomination (services, activities, positions held). **Deadline is Oct. 30, 1998.** Send your nominations to: *Ohio Medicine*, Young Physician Recognition, 3401 Mill Run Dr., Hilliard, OH 43026. ■

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Medicare discontinues quarterly updates

In the June edition of *Medicare Newsletter*, Nationwide announced that "Due to our present budget restraints, we will no longer print and mail quarterly updates to the *Medicare Part B Medical Policy Manual*." This became effective this month.

The carrier will print one additional update in August for policies up to July 1998. Policy information will continue to be sent to you in the *Medicare Newsletter*. New policies will be printed on pages in the newsletter so you can remove them and place them in your *Medical Policy Manual* for easy reference. The *Medicare Newsletter* is the official notice to the provider community, regarding your responsibilities and obligations under the Medicare program.

Effective immediately, requests for additional copies of the *Medicare Part B Medical Policy Manual* and the *Medicare Newsletter* will no longer be honored over the telephone.

Additional copies may be obtained by writing to:

Nationwide Insurance Enterprise
Medicare Operations
Disclosure/Freedom of Informa-
tion

P.O. Box 182195
Columbus, OH 43218-2195.

The OSMA has expressed concerns to Nationwide-Medicare about this policy and as a result the carrier will form a task force to examine its communications with providers and determine if there is a better way to release policy information. The task force is expected to make recommendations in six months.

"I'm encouraged by the interest from the carrier staff," says OSMA Ombudsman Services Director Bill Fry. "They assured us their intention is to produce an information system that is compatible, usable and at the least cost to providers." ■

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Publication of the Ohio State Medical Association

Publication of the Ohio State Medical Association

4

The OSMA has adopted legislative positions on 10 bills that, if passed, will affect the way you practice medicine.

8

What do you know about releasing medical records? What you *don't* know may cost you your license.

10

Supreme Court
Chief Justice Thomas J.
Employer defends the new
law that drops your ex-
emption from jury duty.
What do you think? See
tax-back form on this is-
sue.



12

Hospitalists are not just practicing in California. Ohio is beginning to see this trend take place at several locations around the state.

Check out the
OSMA's new site
map on our Web
site at
www.osma.org

OSMA's election guide helps define pro-medicine candidates

Legislative candidates have been asked pointed questions by the OSMA regarding their stand on HMO accountability, and tort reform.

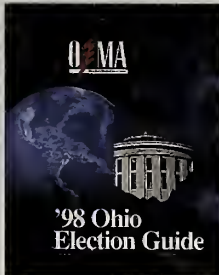
Need some help deciding who to vote for in the 1998 elections? The OSMA has published the 1998 Ohio Election Guide which profiles candidates' stances on key issues that affect doctors.

All members of OMPAC (Ohio Medical Political Action Committee) and PLAN (Physician Legislative Action Network) will soon receive copies of the guide which includes profiles of candidates, including their districts and responses to an OSMA survey. If you aren't a member of OMPAC or PLAN (but are a member of the OSMA) you

can also order a copy. See "Take Action" on page 3 for ordering information.

The association published an election guide in 1996 and it received such favorable response that the OSMA decided to print one this year, says Krista Bistline, OSMA's political affairs coordinator.

"They loved the '96 Guide. Doctors said it was informative, helpful and easy-to-read," she says. "We hope the



guide educates our members on the candidates and that it persuades them to vote."

The guide devotes a page to each of the 99 House seats and 18 Senate seats up for election this year. You'll be given:

- a profile of each candidate's district, including the area's population, minority population, gender, age, education level, employment by industry, median household income and median home value;

- background information on the candidate's past elected offices, occupation, education and activities.

In addition, you'll be able to gauge the candidates' stance on important health-care issues by reading their re-

continued on page 3

New Workers Comp form to resolve charge of unauthorized practice of law

If you need to report initial diagnosis or allowances for additional conditions on BWC forms, use form C-9. Using form C-86 may mean you are engaging in the unauthorized practice of law.

Consultants of Cincinnati. The committee said the doctors had engaged in the unauthorized practice of law because they had helped several patients complete form C-86, distributed by the

Bureau of Workers' Compensation
(BWC).

According to the UPL committee,

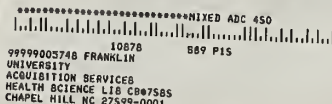
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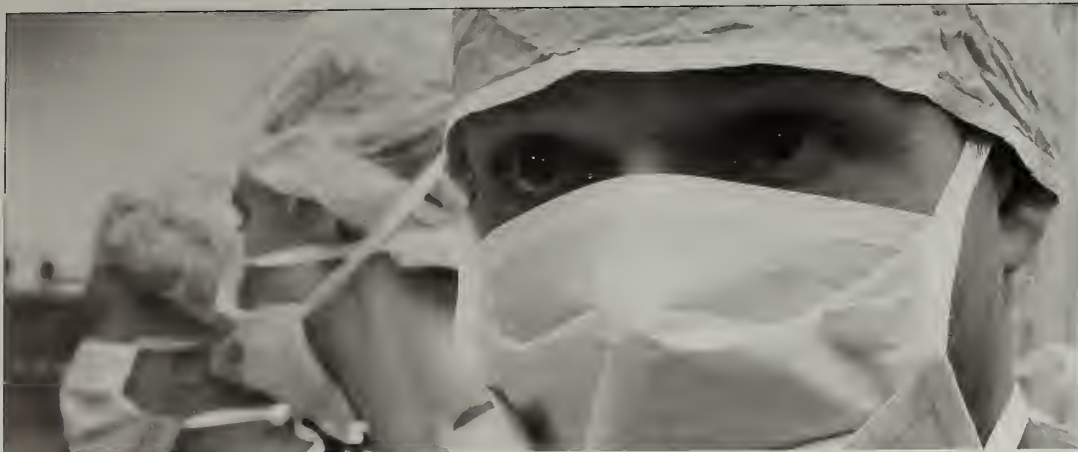


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Over a year ago, the Cincinnati Bar Association's Unlawful Practice of Law (UPL) Committee filed a complaint against physicians with Wellington Orthopaedic





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BWC....

continued from page 1

Form C-86 was developed for attorneys' use in filing motions requesting BWC action on a claim. The physicians' role in completing the form amounted to unauthorized practice of law because the form could become evidence if the individual's claim is denied and an appeal is filed.

Now, the attorneys and physicians have apparently resolved the matter. At a joint meeting in Cincinnati on Aug. 6, members of the Cincinnati Bar, BWC, the Academy of Medicine of Cincinnati and other interested parties decided to ask physicians to use form C-9 for workers' compensation claimants, says Tom Sant, a BWC staff attorney.

Reporting initial diagnosis

Form C-9, a new form developed last year, was mailed with an instruction packet to certified BWC providers across the state several weeks ago.

Physicians may use form C-9 to report initial diagnosis and allowances

for additional conditions to the BWC, says Douglas Maser, chief of the bureau's Medical Division. The form was specifically designed for physicians' use as part of a notification process in workers' compensation cases, Sant adds. It will trigger notices to all parties involved in a claimant's case.

Change in diagnosis

The other form, C-86, had been used for the past decade or so to notify the bureau for additions to or changes in the diagnosis on a workers' compensation claim, says John Larkin, MD, an orthopedic surgeon, member of BWC's Medical Advisory Committee and chair of the Academy's Legislative Committee. It had originally been designed by the bureau as a method for injured workers to petition for an amendment to an original claim, he says.

"An injured worker wouldn't know what to put on the form to support the diagnosis for the claim," Dr. Larkin says, so typically, the physician's office notes about the patient's condition were attached, or an office staff mem-

ber completed the form, which the patient then signed and sent to BWC. Apparently, notification of such changes in the patient's claim did not always reach the attorneys involved, he says.

Members of the joint committee will inform UPL members that the bureau will be using the new form. "As doctors embrace the new form and use it, that should take care of any issues," Maser says.

"Thanks to the efforts and cooperation of everyone involved, this matter has been resolved," says Fred McGavran, chair of the Joint Committee of the Cincinnati Bar Association and Academy of Medicine. — Anna Rzewnicki

Web resource

For more information about the BWC, see their site at www.bwc.state.oh.us/home/home.htm or link to it from the OSMA site www.osma.org

OSMA pain handbook due out late this year

Pain – The Fifth Vital Sign, a clinical manual for Ohio physicians is currently in the final phases of editing. The handbook has been developed by the OSMA's Ad Hoc Pain Advisory Committee. Statewide distribution of the publication is anticipated late this year. The manual looks at recommended clinical approaches and available forms of treatment for chronic pain. The manual also will include the new Medical Board of Ohio rules on the treatment of pain. The OSMA continues to work with the medical board in the development of easy-to-understand guidelines for prescribing controlled substances for patients with pain.

"It is our hope that in addition to serving as a broad and useful resource, the handbook and checklist will ease physicians' concerns when prescribing medication for patients with chronic intractable pain," says Warren Wheeler, MD, a member of the committee. ■

Election....

continued from page 1

sponses to a one-page survey distributed by the OSMA. The survey provided them with the OSMA's policy statements on HMO accountability, allied medical providers and tort reform. After reading through each statement, they were then asked to answer the following questions:

- Should patients be able to hold HMOs accountable for medical insurance coverage decisions if the denial of insurance coverage causes physical harm to the patient?

- Do you oppose attempts by allied medical providers from being allowed to diagnose and prescribe courses of treatment if those activities could be defined as the practice of medicine?

- Do you oppose attempts to raise the limits on noneconomic damages under HB 350, the tort-reform law passed in 1996?

Bistline says the candidates' answers to these questions will help doctors "read through the lines" to see how a particular candidate may vote on a

physician issue.

"If candidates don't think HMOs should be held accountable or if they are 'pro-insurance agencies,' doctors need to know that," she says. "The guide will help physicians vote a person in who supports physician issues. It's much easier to get bills passed if you have a pro-physician or pro-patient legislator." — Kaci Brown

Take Action

If you have questions about the 1998 Ohio Election Guide, contact Krista Bistline, OSMA Department of Legislation, (800) 766-6762, Ext. 6748. If you would like to order a copy of the Election Guide, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580 and ask for item 28-98. There is no charge for the guide.

Next month's issue of Ohio Medicine will feature more election news.

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Bills, Laws & Rules

New legislative positions set

The OSMA has adopted the following positions on legislation, recommended by the Committee on State Legislation:

HB 714 – Osteoporosis Insurance Coverage

What the bill does: The bill requires health insuring corporations and benefit plans to provide services related to the diagnosis, treatment and appropriate management of osteoporosis.

Sponsor: Rep. Sam Britton (D-Cincinnati)

OSMA Position: Neutral. Although the OSMA House of Delegates has no policy on mandated benefits, the association has traditionally remained neutral on this type of legislation.

HB 717 – Automated External Defibrillation

What the bill does: Through this legislation, physicians who provide prescriptions for an Automated External Defibrillator (AED) and those who use them will be granted qualified immunity – the same immunity protection as individuals who use CPR in emergency situations.

Sponsor: Rep. Rose Vesper (R-New Richmond)

OSMA Position: Support. Although the association does not have policy regarding the use of AEDs, it did contact the Ohio Chapter of the American College of Cardiology which says it agrees with the Ohio Chapter of the American Heart Association's decision to support the bill.

HB 718 – Mental Health Parity

What the bill does: If House Bill 718 passes, it will prohibit discrimination in the coverage of severe mental illness in all health insurance contracts and

policies in Ohio. The bill specifies that severe mental illness can be diagnosed by licensed physicians, psychiatrists, psychologists, and other mental health professionals. The legislation also specifically states the types of mental health illness the provisions cover: schizophrenia, bipolar disorder (manic-depressive illness), major depression, panic disorder, obsessive-compulsive disorder and schizo affective disorder.

Sponsor: Rep. Lynn Olman (R-Maumee)

OSMA Position: Support. Based on information from other interested parties, the OSMA supports this bill although it has historically been neutral or has opposed insurance mandates. Data supplied from organizations such as the Ohio Psychiatric Association and the *Journal of the American Medical Association* suggest that mental health coverage is affordable and cost effective.

HB 719 – Duty to Warn

What the bill does: The bill establishes a statutory duty for mental health professionals to warn or protect others against a patient's threat if he or she believes the client will carry out the threat. If the professional does not warn of the potential threat, and harm or serious injury results, he or she may be held liable for damages in a civil action or be subject to professional discipline.

Sponsor: Rep. Rose Vesper (R-New Richmond)

OSMA Position: Support. The OSMA, which supported the legislation's concept at an earlier Legislative Committee, joins many diverse health care related organizations in supporting this bill.

HB 720 – Any Willing Pharmacy

What the bill does: Pharmacies not listed as a participating pharmacy by an insurer or health insuring corporation will be able to dispense drugs to patients and be covered for those services if the nonparticipating pharmacy is willing to meet the same terms and conditions as pharmacies included in the plan.

Sponsor: Rep. William Batchelder (R-Medina)

OSMA Position: Neutral. Although the OSMA has policy supporting "Any Willing Physician Provider," this bill has been described by the sponsor as different from that concept since it covers a product and not a service. "Basically, it's the pharmacist's bill," says Tim Maglione, OSMA Legislative director. "And the OSMA is exploring more viable access issues in the legislature, like point-of-service options."

HB 734/SB 239 – Rural Hospital Employment of Physicians

What the bill does: These two bills, House Bill 734 and its companion bill, Senate Bill 239, would permit rural hospitals to directly employ physicians.

Sponsor: Rep. William Ogg/Sen. Doug White

OSMA Position: Under Advisement. Last year, the Council approved a neutral position on the corporate practice of medicine bill (Senate Bill 31), authorizing physicians to engage in a combined business form with nonprofessional entities. At the same time, however, it looked at the issue of whether a rural hospital should employ physicians and took a neutral position. The OHA: Association for Hospitals

Handicapped placards would require prescription

Currently under Ohio law, patients applying for handicapped parking placards need to complete an application with a signed statement from their physicians, certifying they meet at least one statutory requirement for receiving the pass.

Under a new measure, introduced this spring, patients would be required to have a prescription from their physician, verifying they meet at least one of the criteria for obtaining a card. Mary Ann Myers, MD, chair for the Governor's Council on People with Disabilities, says she hopes the bill will crack down on the abuse of the handicapped placard, yet still make it available.

Under the current draft of the bill, a physician who furnishes a placard to a patient who does not meet the criteria or who knowingly misstates the length of time the person is expected to have the disability, will be guilty of a misdemeanor of the first degree.

The OSMA is working to change this provision so the physician will be referred to the State Medical Board instead of facing a misdemeanor charge, says Marla Eshelman Bump, associate director of OSMA's Legislation Department. She says she spoke with the sponsor, Rep. Bryan Williams, who agrees to change the penalty to a referral.

Council was concerned with the penalty language and voted to keep the bill under advisement. Councilors also requested a report back on why the bill contains the misdemeanor penalties for physicians. – Kaci Brown

Sponsor: Rep. Bryan Williams (R-Akron)

OSMA position: Under Advisement

continued on page 6

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Formularies will need physician input

Soon physicians will have a say in how health insuring corporations develop their formulary lists. In October, when the Physician Health Plan Partnership Act (PHPPA) becomes effective, doctors will comprise a portion of the committee that makes up the drug formulary list.

This provision will help patients feel more at ease knowing their physicians have a say in what medications they will prescribe, says Nick Lashutka, OSMA's Department of Legislation, who helped write the bill.

"This section is a strong patient protection measure that we believe will greatly benefit Ohioans who are apprehensive about how HICs (Health Insuring Corporations) develop their drug formularies," he says.

The bill's provision requires HICs to develop a formulary list with the help of a pharmacy and therapeutics committee if the corporation's policies, contracts or agreements use a restrict-

ed formulary of prescription drugs.

Health Insuring Corporations have two options for establishing this committee that must help develop and approve the list. A majority of its members can be comprised of affiliated pharmacists and physicians, who may prescribe prescription drugs. Or HICs can establish a committee that is independent of the corporation, which consists of physicians who may prescribe prescription drugs in their state and pharmacists who are authorized to practice in their state of licensure.

PHPPA also establishes a procedure which allows enrollees to obtain an alternative drug, not found on the list, if the formulary drug is ineffective in the patient's treatment or causes a harmful or adverse reaction. Enrollees may obtain these drugs without penalty or additional costs beyond that provided for formulary drugs under his or her contract.

Allowing physicians to help formulate these lists is likely to alleviate

problems in the future, Lashutka says.

"A significant component of this section is part of a theme throughout this legislation, physicians involved in the plan must have input into medical management issues," he says. "This safeguard will hopefully prevent problems from arising by ensuring physi-

cian involvement on the front end of the system developing these formularies."

If you have any questions about this provision, or about the PHPPA in general, contact Nick Lashutka, OSMA Department of Legislation, (800) 766-6762, Ext. 6747. — Kaci Brown

Positions... continued from page 4

and Health Systems support the rural employment of physicians, but would like to expand the legislation beyond rural hospitals. Sen. Grace Drake, chair of the Senate Health Committee, says she will not support expanding the legislation, says Krista Bistline, OSMA Department of Legislation. Although the committee recommended a position of support on the bill, the Council changed the OSMA position to under advisement. Councilors requested a report describing how rural hospitals are defined and what happens if rural hospitals are purchased by nonrural hospitals.

HB 766 — Oral Contraceptive

What the bill does:

House Bill 766 will require a variety of insurance entities in Ohio to provide coverage for oral contraceptives. It will affect the following insurers: sickness and accident, public employee benefit plan and health insuring corporations.

Sponsor: Rep. Marilyn Reid (R-Beavercreek)

OSMA Position: Support. The OSMA has official House of Delegates policy (Resol. 11-98) that supports prescriptive equity for contraceptives. However, the legislative committee still expressed reservations about mandated benefits.

Senate Bill 240 — ONA Patient Safety Act

What the bill does:

Introduced at the request of the Ohio Nurses Association, Senate Bill 240 will prohibit unauthorized persons

from doing nursing tasks unless delegated by a registered nurse. The bill increases penalties for the unauthorized practice of nursing and sets up a toll-free number to report violations to the appropriate regulatory agency. The bill requires that health-care providers report to the Ohio Department of Health certain facts about patient outcomes and the use of nurses, which will be held as public record.

Sponsor: Sen. Grace Drake (R-Solon)
OSMA Position: Under Advisement. OSMA put the bill under advisement because of its definition of nursing tasks. A legal review of the bill indicates a physician may be prohibited from delegating certain duties to nonlicensed personnel.

Senate Bill 241 — Newborn Screening

What the bill does:

This bill will delete from statute the list of specific diseases that newborns are screened for at birth. Instead of listing in law specific disorders to check, the bill will authorize the Public Health Council to identify which disorders must be screened for and designate who will conduct the screening. Physicians, nurses and other health-care facility employees involved with the newborn's care, can request the screening results without acquiring parental consent.

Sponsor: Sen. Grace Drake (R-Solon)
OSMA Position: Support. The committee supports the bill on the basis that it allows greater flexibility of what tests need to be conducted on newborns. — Kaci Brown

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Med board bill nears passage

The most important part of House Bill 606 (sponsored by Rep. Kirk Schuring, R-Canton) is what the bill does not contain.

When the legislation was introduced, physicians indicted for a felony would have had their licenses suspended – before they were convicted of the crime. The OSMA worked to delete that section of the bill, in addition to a provision that would have allowed the board to order a physician to have an HIV test if it believed the licensee has an HIV infection. Close monitoring by your association allowed these sections to be dropped early in the legislative process.

As it now stands, HB 606 provides the following:

- The State Medical Board has the authority to permanently revoke a physician's license. Recently, this authority has been questioned by appeals courts. The new law leaves no doubt of the board's power in this area.

- A physician who abuses substances is subject to discipline, even if a court refers him or her to a treatment program in lieu of a conviction.

- HIV/AIDS is treated like any other condition that has the ability to impair a physician's practice, and the board is empowered to order HIV/AIDS testing (but this may be done anonymously and the physician must consent.)

- The board may act on the fact that a physician has surrendered a medical license in another jurisdiction, even though he or she may not have admitted wrongdoing in that state.

- A physician-defendant in a criminal case can't raise physician-patient privilege to keep evidence of criminal conduct out of the case.

- Residents, interns and fellows will be required to register with the board and obtain training certificates. This allows the board jurisdiction over doctors practicing in Ohio who are completing their training.

Medical Board Report

The OSMA supported the board's bill, once the onerous sections were removed. The measure is expected to pass the Senate and to be sent to the governor for his signature.

Of note...

Should alternative therapies be certified?...The board's Limited Branch and Alternative Medicine Committee is working on a list of different alternative medicine therapies that are practiced in Ohio. Once the list is complete, the board is likely to determine which therapy may be appropriate for certification.

Laser surgery discussions continue...Lasers are another surgical modality says the Minimal Standards Committee, and because the number of laser procedures continues to increase, the committee believes rules are needed to assure that laser use stays within minimal standards of care. One board member raised the issue that the Ohio Department of Health may also be studying the prospect of setting standards for laser use – but it was noted that the health department's authority is most likely to be in the area of equipment regulation. The board is more concerned with who is using the machine and how. ■

Resolution Report: 28-98

Federal "bill of rights" would expand law

- Patients have the right to candid health-care discussions with their physicians.

- Patients have the right to know the details of their plan and its policies.

- Patients have the right to have their case reviewed by a medical professional when a medical procedure has been denied them.

- Patients have the right to emergency treatment when, as a prudent layperson, they believe their situation is an emergency.

- Patients have the right to hold plans fully accountable and liable.

These five "key" rights are included in federal legislation, known as the "Patients' Bill of Rights," that is supported by both the OSMA and the AMA.

This bill, also known as the Dingell-Daschle bill, compliments Ohio's own managed-care reform law, the Physician Health Plan Partnership Act (PHPPA), which, at a state level, already:

- prohibits gag clauses;
- provides for full disclosure of health-plan coverage details;
- establishes a prudent layperson standard for coverage of emergency services, and;
- grants the right of external appeal for denied experimental treatments.

Although the managed-care accountability issue is not addressed in PHPPA, three bills on the subject have been in-

troduced at the Statehouse, and the OSMA is in favor of the concept.

In May, the OSMA House of Delegates directed the association to formally state its support of the patients' bill of rights, promulgated by the AMA. That action was taken in mid-summer, when the Division of Public Affairs issued a news release announcing the OSMA's support of the Dingell-Daschle bill.

The news release pointed out that, although Ohio had passed an excellent managed-care reform law that goes into effect in October, the new law will not cover persons whose employers provide them with ERISA-exempt health insurance (about 50% of employed Ohioans).

"Enacting federal patient protection legislation will assure that all Ohioans have access to the same safeguards that will become available to only about half of the insured population in October," says Lance Talmage, MD, OSMA president, in the news release. "We are very pleased with what the Ohio Legislature has accomplished to reform managed care in this state," he continues. "The federal legislation will expand these protections and make them applicable to all insured Ohioans."

The news release was distributed to newspapers and television stations across the state, as well as to city magazines and governmental news services and agencies. ■

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Legal Review

What you must know about releasing medical records

According to the AMA's Code of Ethics, not releasing records – for whatever reason – violates the patient's continuity of care. And that could cost you your license.

Your medical records may be part of your personal property, but according to the State Medical Board of Ohio, the OSMA and the AMA, your patients have a right to view them, and even obtain a copy of them. Withholding patient records – for unpaid balances or any other reason – may land you in serious trouble.

Although most states have statutes authorizing patient access to records, Ohio laws don't directly address this topic, so any guidelines on releasing records are necessarily vague. The medical board, however, can discipline a physician for failing to comply with the AMA's Code of Ethics, and when you fail to release your patient's records when presented with valid authorization and consent to release, that's a violation of the code, says Lauren Lubow, case control officer at the medical board.

So how do you avoid trouble, and help your patients at the same time?

What should you release?

The AMA recommends that physicians be forthcoming with their records. In its "Opinions on Physician Records," the AMA's Council on Judicial and Ethical Affairs (CEJA) states that the interest of the patient is "paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient."

The AMA opinion continues: "A physician who formerly treated a patient should not refuse for any reason to make records of that patient promptly available on request of another physician presently treating the patient."

Records may also be given directly to the patient.

Although by no means binding, the following guidelines, extracted from the AMA's Opinions on Physician Records, may be helpful:

Do:

- Obtain the patient's consent before releasing medical records. Medical records are confidential documents involving the physician-patient relationship. They should not be communicated to anyone without the patient's written, signed consent. Before releasing any record, the physician should examine the consent to assure the signature is authentic and is by a person of majority (18 years in Ohio.) The consent should cover what documents are requested and the person or entity to whom the information is to be revealed. The physician should

keep all original records.

- Be aware of special authorization requirements for releasing information regarding AIDS, artificial insemination, drug and alcohol abuse and mental health records. If you are releasing records to out-of-state physicians, become familiar with the applicable laws governing patient access to medical records in that state.

Don't:

- Withhold medical reports because of an unpaid bill for medical services.
- Release information to third parties without having the patient sign a release.
- Charge exorbitant fees for copying records. (See "What Should You Charge?")

Keep in mind that the guidelines in this article are only suggestions. Be-

cause Ohio has no laws on the subject of physician office medical records, there are no hard and fast rules you must follow. Stay within the AMA's guidelines, however, and chances are, you'll be acting within the best interests of your patients. ■

Take Action

If you have questions about releasing medical records, contact the OSMA's Division of Legal Affairs, (800) 766-6762. The OSMA's *Physicians Guide to Ohio Law* features the AMA's *Opinions on Physician Records*, and the OSMA fact sheets contain several pages on the subject. If you would like a copy of the OSMA's fact sheet on medical records, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580 and ask for Item 29-98. Or see the OSMA's Web site, (www.osma.org) which includes all OSMA's fact sheets.

What should you charge?

The AMA suggests you charge a "reasonable fee" for copying records requested by a patient. According to the Council on Judicial and Ethical Affairs (CEJA), the amount charged should be based on the cost to the physician to photocopy the records or otherwise provide the information through a dictation or summary. The CEJA also states that physicians should complete "simplified" insurance claims forms without charge. If the form is more complex, then a more appropriate charge could be made, as long as it is in keeping with local custom. It's also a good idea – before you charge – to check your contract with the patient's payor. Your contract with the payor may control whether or not you can bill the patient

a copying charge. Keep in mind, too, that third-party payors, including the government, may not honor your request for a copying fee.

At present, there is a bill at the Statehouse (Senate Bill 268) that specifies the fees health-care providers and health insuring corporations may charge for providing medical records. Sen. Louis Blessing, Jr. (R-Colerain Township) is sponsoring the bill that would cap the medical records charge at 15 cents a page, plus taxes and postage costs. Without legal restrictions on charges, however, some hospitals in the state are charging fees as high as \$150 a page to copy patient records. In one case, a Hamilton County Common Pleas Judge ruled on a case involving a bill from a contractor,

hired by Mercy Hospital Fairfield to process record requests. The contractor charged the patient about \$125 for 87 pages of records. The judge ordered the hospital to cut its price to 20 cents per page plus tax. The new total: \$18.44.

Sen. Blessing's bill has been introduced, but it's by no means the first bill on this subject. Other attempts to restrict fees for copying medical records have been defeated. Sen. Blessing's bill is expected to also come under heavy opposition from hospitals and companies that contract to handle medical records. *Ohio Medicine* will update you as this legislation develops. ■

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Forum

Juries should reflect communities

Editor's note: In accordance with House of Delegates policy, the OSMA is monitoring the effects of the law (Senate Bill 69) that removed physicians' exemption from jury duty. If you are experiencing problems with jury duty, contact Katrina English, director, OSMA's Division of Legal Affairs, (800) 766-6762, Ext. 6768, e-mail: kenglish@osma.org

By Thomas J. Moyer

Earlier this year, the Ohio General Assembly joined 35 other states when it eliminated all statutory exemptions for service as a juror. Ohio law previously exempted such professions and occupations as lawyers, physicians, certain members of the clergy, and persons serving in the National Guard. The jury system, created in response to the tyranny of monarchs, reflects our belief that a citizen is entitled to be judged by a panel of his or her peers. The reason I requested the General Assembly to eliminate the exemptions derived from my belief that the ideal jury is a reflection of the community. It is that theory that has caused us in America to view jury service as a duty of citizenship. It follows that all citizens, subject to relief from the duty for hardship, must be available for jury service if juries are to reflect the community.

In fact, a study performed by an expert on juries observed recently that the paucity of business persons serving on juries has had a negative impact on verdicts in cases in which business interests were involved.

It is important to note that any citi-



Thomas J. Moyer

Second Opinion

zen called for jury duty may be excused by a judge for good cause. In many counties, the schedule of professional persons and others may be accommodated by the court. In a relatively new approach, the prospective juror is on call at a workplace or at home and responds to a telephone call when he or she is needed for jury service.

Members of the medical profession pose unique challenges to jury service. They also have a direct interest in the composition of juries. I encourage your views directed at making jury service as convenient to your profession as possible ■

Thomas J. Moyer is Chief Justice of the Supreme Court of Ohio.

Ohio Medicine would like your comments on the article by Chief Justice Thomas Moyer. Please use the fax-back form located in this issue to make your comments, or address them, via e-mail, to: Karen Edwards, editor, at: ohioned@osma.org

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Indepth Report

Tracking the trend

Have hospitalists moved into Ohio?

Has the hospitalist trend, popular on the West Coast reached Ohio? Hospitalist, of course, refers to those physicians who spend at least 25% of their professional time serving as physicians-of-record for inpatients. Hospitalists see patients in lieu of their family physicians, returning the patient back to the care of the primary care physician at the time of hospital discharge.

That's a rough definition. The trend is so new that, as one doctor in *AM-News* reports, job descriptions for hospitalists are all over the map. But there is no question that the trend is spreading across the country. The first meeting of hospitalists occurred in April 1997, and this past spring, the first annual meeting of the National Association of Inpatient Physicians (NAIP) took place.

The trend is beginning to appear in Ohio, as well. As is the case across the country, the inpatient physician model in Ohio has taken several forms. They are explored here.

Mt. Carmel Medical Center, Columbus

After 10 years in a traditional private practice, internist John Dell, MD, became an inpatient specialist in 1989, practicing as an active staff member at 462-bed Mount Carmel Medical Center in Columbus. His inpatient referrals come from orthopedists, neurosurgeons, cardiologists, urologists, gynecologists, general surgeons and several private family practitioners. He also covers inpatient care during family practitioners' vacations. The hospital itself does not "feed" him patients.

His average census is about eight,

and average length of stay is about five days (seeing both regular and surgical patients) with one-to-two new patients each day. About half of his patients are referred through the emergency department, and from family physicians; the other half are consult/medical management patients. He assesses and manages some critical care patients, often admitted from nursing homes. And he handles pre-admission testing at the hospital and in a spine surgeon's office.

He believes that his physician-clients and their patients benefit from this thoroughness in testing and communications. His reports are transcribed and mailed to the referring physicians by hospital support staff.

"By being an independent private physician," he says, "I'm not involved in hospital politics. An in-house advocate can't be as aggressive in seeking information and quality of care. This arrangement is optimum for both the inpatient and the referring physician."

"There is no typical day, and I average about eight hours per day at the hospital, plus several more hours for paperwork. It's difficult to plan a day, and I'm on call 24 hours, seven days a week. On the other hand, this arrangement has a lot of flexibility, and I can generally spend whatever time's necessary with individual patients."

And with this flexibility, he rarely turns down consults. "Referring physicians don't see me as a threat to their practices since I don't have an office," says Dr. Dell.

Mercy Hospital Fairfield

For hospitalist services, Mercy Hospital Fairfield, in northern Hamil-

ton County and Butler County, is served by a rotating group of independent physicians. Anthony Behler, MD, is one of them.

He first learned about the concept in an August 1996 editorial in *The New England Journal of Medicine*, and the idea was reinforced by a seminar he attended on the subject. All of the members of his group practice, Internists of Fairfield, already had hospital privileges at Mercy. In January 1997, they approached the hospital executive committee about a possible phase-in of hospitalist services. The program began on July 1 last year.

"Initially, most parties were very enthusiastic," says Dr. Behler. "Everyone could see the benefits to patients, referring physicians and the overall system. Only one individual was vocally opposed, and today, one year later, he's decided to live in harmony with it."

Three of the practice's internists rotate two weeks of outpatient practice with one week of full-time hospital responsibilities. They handle their own group's inpatient needs, as well as those of seven family practitioners, plus several others. Because of the nature of the group practice, their initial daily census was 12 to 15. Now, seven to eight patients have been added to that figure.

"After the first six months, several improvements can be attributed to the program," says Dr. Behler. Average length of stay has decreased one-half day, and substantial, measurable, monetary savings have been realized, he says.

Dr. Behler anticipates increased uti-

continued on page 13

What they say... about hospitalists

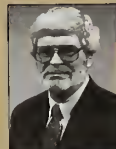
"For the hospitalist model to be accepted and thrive, the hospitalist will need to act as a consultant to the patient's primary care physician, who will continue active, daily hospital management. A successful hospitalist will exhibit effective interpersonal skills that will avoid disenfranchising the patient's primary care physician. I suspect the relationship will work best when the two physicians are practicing within a common medical group entity...Before physicians and managed-care plans and hospitals endorse the concept, however, studies should examine this question: Which more effectively results in superior, long-term clinical outcome and patient satisfaction, improving the hospital management skills of the generalist, or delegating hospital management to the new hospital specialist?"



Dr. Severyn

Steven A. Severyn, MD
chair, OSMIA Organized
Medical Staff Section

"I feel that the hospitalist trend will continue to increase due to the pressures of managed care and the decrease in the availability of the primary care physicians to manage their patients in the hospital. The way many aspects of care now occurs is that the primary care physician directly refers to other subspecialties within the



Dr. Longenecker

continued on page 13

What they say...

continued from page 12

hospital, and there are few physicians who are involved to manage, or at least direct, the care from an integrated basis. Consequently, the hospitalist could well become the physician of a general nature who works entirely within the hospital, who facilitates and directs the care given by other subspecialties within the institution to allow more efficient, economic use of hospital facilities.

Douglas P. Longenecker, MD
Council representative
OSMA Group Practice Section

"Hospitalist" is a new name for a not-so-new but increasingly popular practice, especially among large groups of physicians. It makes a great deal of sense to have a dedicated physician on-site in the hospital, familiar with all its inner workings and available to see patients on short notice. In today's environment of intense pressure to deliver high quality care in an economical manner, hospitalists can save time and money while helping to improve health-care outcomes."

John Callender
senior vice-president,
OHA: Association of Hospitals
and Health Systems

"At the June 1998 AMA Annual Meeting, the Organized Medical Staff Section and the House of Delegates discussed, amended and adopted Council on Medical Service Report 4 - "The Emerging Use of Hospitalists." The primary concerns within this report were patient and managed-care enrollment notification of hospitalist programs, developing and following med-

ical staff bylaws consistent with the AMA policy of medical staff self-governance, voluntary nonpunitive implementation by physician and patient, and opposition of any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and/or jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants."

Stephen T. House, MD
alternate delegate, AMA-OMSS
Governing Council

"The use of hospitalists should remain a physician's choice, in the interests of their patients and their own personal time commitments. The relationship should be defined by open communication and readily available transfer of information, as well as care to avoid duplication of efforts and waste of resources and materials, while providing optimum patient care. Physicians using hospital specialists should work toward an effective bilateral relationship that will be seamless with respect to the patients and their families. Mandated use of hospitalists is an inappropriate intrusion in the physician-patient relationship. Physicians who continue to care for their own hospitalized patients do so with the intent of maintaining effective and efficient continuity of care.

Ross R. Black, MD
past president,
Ohio Academy of Family
Physicians



Dr. House

Hospitalists...

continued from page 12

lization as other primary care physicians see the benefits and as threats to their practices are assuaged by others' experiences.

David Ferrell, president of Mercy Hospital Hamilton/Fairfield, advises that "much depends on your staff culture, internal politics, and the hospitalists' credibility. We've successfully designed a methodology to incentivize the hospitalists and to track the success of the program. And we're well on the way to developing a network of referring primary care physicians."

Akron General Medical Center, Akron

"We want it now, not tomorrow," was the largely positive response to an anonymous physician survey about hospitalist services conducted by Akron General Medical Center, recalls Richard Streck, MD, senior vice president, medical affairs. Both generalists and subspecialists in the 511-bed facility were included in the survey.

The biggest concern expressed had been the need for excellent communication between referring physician and hospitalist during the patient's hospital stay. The conclusion was to not create the structure and then hire hospitalists to fulfill it. Instead, the hospital leadership decided on a transitional program that would allow the hospitalists to design the program, as it evolved.

"We had quite a bit of interest in the position from general internists, and also from our current residents," says Dr. Streck.

As of Aug. 2, three board-certified general internists (who had approached

Dr. Streck when they learned of the "hospitalist" survey) were brought on board to become familiar with the medical staff and hospital. For the first year, the three will not have outpatient practices, and will be employed by Akron General as "house physicians" rather than as hospitalists.

The difference, says Dr. Streck, is that a hospitalist would have responsibility for physician-referred inpatient care throughout the patient's stay. At this point, the house physicians will have a rotating "firefighter" role, working nights and weekends. At the request of attending physicians, they will conduct acute assessments and interventions, one-time diagnoses and therapeutic interventions.

"Right now, we don't have all the answers," says Dr. Streck. "Some of the questions that will be resolved through experience and perhaps a more scientific survey are issues of hospitalist demand and employment status. We're not boxed in, and want our physicians to have as much input as possible." — Carol Larimer

Hospitalists facts

The National Association of Inpatient Physicians estimate:

- There are 2,500-3,000 hospitalists in practice.
- Average salary: \$145,000.
- Hours worked per week: 58.

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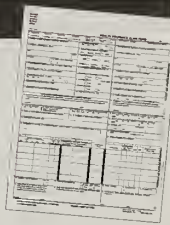
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OSMA News



OSMA focuses on meeting individual members' needs

The traditional broad-based approach to serving members is no longer effective. That's why OSMA's new membership development manager will divide OSMA membership into specific demographic groups to determine how the association can best serve individual needs.

Many elements of the Task Force 2000 report sought ways to make the OSMA more responsive to members' needs. In response to the report that was presented to the House of Delegates in May, the association is refining its mission to respond to the needs of its members in a changing health-care environment.

That's why Lucy Mullis has joined the staff as membership development manager. The job's focus, at least initially, will be on meeting member needs.

"I'm dividing our membership into specific demographic groups," she says. From these groups, Mullis will determine not only how the OSMA is meeting members' unique needs, but also what products or programs can be created to better serve them.

"We want to concentrate, first, on keeping our members," says Doug Evans, director of the Division of Membership Services. But concurrent with stabilizing the present membership base will be the implementation of new recruitment programs.

The OSMA, like many organizations today, has seen its membership drop. According to tabulations presented to the Council in July, the association had a total of 10,766 dues-paying members in 1996 and a total of 10,651 in 1997. As of July 1998, membership stands at 9,956 (compared to 10,536 in July '97.)

Mullis, the former vice-president of marketing and membership services for the Roanoke (Virginia) Regional Chamber of Commerce, plans to focus first on International Medical Graduates, rural and women physicians, working to meet each group's specific needs. Eventually, she will expand her efforts to include osteopaths, minority and academic physicians as well as physician-executives, among others.

"We realize that we can no longer address our physicians' needs by considering them as a whole," says Evans. Each OSMA member has individual needs, and it is Mullis' job to determine what those needs are, realizing that many physicians will be in two or more demographic target audiences, says Evans.

The OSMA's Membership Services Division is already taking the pulse of certain segments of members. Susan Rupli communicates regularly with members in large group practices (more than 10 physicians), and Shar Wackman stays in touch with members of Organized Medical Staffs, young physicians, students and residents. In addition, Ben Reynolds, OSMA's field representative (a pilot project) contacts Northeast Ohio physicians on a regular basis.

This staff research, in addition to Mullis' own field work, is an invaluable tool in formulating new programs and services for members, says Evans.

"The OSMA also has access to a

wealth of information on member needs," he continues. In addition to recent market research information, there is information collected two years ago from regional focus groups and, of course, research compiled by the AMA. Mullis says she also finds the Internet helpful in focusing on specific groups.

"Collating this data helps us better understand the marketplace, and how we can create a presence in it," says Evans.

The two hope to have a plan, encompassing new OSMA activities and services, ready for implementation this fall. Those programs, tailor-made for existing members, will be used to increase membership as well.

"Retention and recruitment go hand in hand," says Evans.

Once Ohio physicians realize the services they're missing by not becoming an OSMA member, they'll join. But it goes back to meeting needs, says Evans.

"The physician needs to know that—whatever situation he or she may be in, the OSMA can help." ■

Who to call

If you have questions or concerns regarding membership, contact one of the OSMA staff members:

- Doug Evans, director, Ext. 6774
- Lucy Mullis, membership development, Ext. 6776
- Shar Wackman, Organized Medical Staff, residents, students, young physicians Ext. 6773
- Susan Rupli, Group Practice Section, Ext. 6775
- Ben Reynolds, field rep, (330) 848-9475
- Jamee Patton, adm. asst., Ext. 6772

Safety should come first

If you are a participant in the OSMA's workers' compensation group rating program you have already realized tremendous savings on your annual BWC premiums. But all practices, regardless of their participation, can lower their premiums by implementing and adhering to a bonafide safety program.

The following nine key parameters are recommended by the BWC to create a safe environment in your practice.

1. **Safety Policy Statement.** A written safety and health policy signed by the top company official should express the employer's values and commitment to workplace safety and health.
2. **Visible Senior Management Support.** Visible senior management leadership should promote the belief that the management of safety is an organizational value.
3. **Employee Involvement and Recognition.** Utilize employee involvement and recognition that affords the opportunity to participate in the safety management process.

4. **Communication.** Implement a program of regular communication on safety and health issues to keep all employees informed and to solicit feedback and suggestions.

5. **Training.** Provide safety orientation and training for all employees.

6. **Written Safety Program.** Publish safe work practices so that employees have a clear understanding of how to safely accomplish their job requirements.

7. **Safety Coordinator Responsibility.**

continued on page 15



Lucy Mullis

Safety...

continued from page 14

bilities. Assign an individual the role of coordinating safety efforts for the company.

8. Transitional Duty. Focus on early return-to-work strategies to help injured workers return to work.

9. Safety Audit Inspection Program. Internal program verification should assess the success of the company's efforts, to include audits, surveys, and record analysis.

For a copy of the self administered test to determine the safety rating of your practice contact Doug Evans at the OSMA (800) 766-6762, Ext. 6774.

For a comprehensive look at how safety can become an integral part of your practice, plan to attend the National Conference on Safety and Workers' Compensation, Sept. 13-15 at the Greater Columbus Convention Center. For more details and registration information, call the BWC Division of Safety and Hygiene at (614) 466-8633. ■

Corrections to '98 Annual Meeting proceedings

The following corrections are to The 1998 Proceedings of the OSMA House of Delegates. The published copy has already been sent to OSMA delegates and alternates.

There are two corrections on page 4:

- Report of the Committee on Nominations: The committee chair was **Bradford Woodall, MD, First District**, not Michael D. Serene, MD, as was reported.

- The following election was omitted from the Proceedings: To be included in column 2, following paragraph 3 – "For alternate delegate to the American Medical Association for a term commencing Jan. 1, 1999 and ending Dec. 31, 1999, the following was elected: **Andres B. Lao, Jr., MD**"

There is one correction on page 5:

- Amended Resolution 02-97 should read **Amended Resolution 02-98**.

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OSMA Profile

A demographic look at your association.

Global medicine

Medicine is a global profession, a fact brought home by the number of International Medical Graduates (IMGs) who have become not only physicians within the boundaries of Ohio, but also participants in organized medicine – including the OSMA. The association has a total of 2,164 International Medical Graduates, and they come from 88 countries around the world. Although the average age of most of these members is between the ages of 50 and 59 years, there are two members each between the ages of 20 and 29 years, and 90 and 99 years.

Many IMG members practice International Medicine (363), but they also represent a number of specialties, including General Surgery (196) and Anesthesiology (145).



Source: OSMA Electronic Data Processing Department

Here's a list of the "Top 10" countries from which OSMA IMG members hail:

- | | |
|----------------------|------------------|
| 1. India (607) | 5. Mexico (106) |
| 2. Philippines (317) | 6. Pakistan (87) |
| 3. South Korea (170) | 7. Iran (60) |
| 4. Canada (116) | 8. Syria (57) |
| | 9. Egypt (52) |
| | 10. Italy (40) |

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AMA Report

House addresses E&M guidelines, Sunbeam

Editor's note: This new monthly column will feature AMA activities and news reports. The OSMA is fortunate to have two members on the AMA Board of Trustees: Herman I. Abramowitz, MD, Dayton and Andrew Thomas, MD, Columbus, (resident trustee).

**By Herman I. Abramowitz,
MD**

Annual Meeting Action

The 1998 AMA Annual Meeting was held in Chicago June 13-18, and a number of important actions were taken by the House of Delegates:

- **E&M guidelines.** The House took decisive action and voted to "oppose any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record." The CPT Panel's proposal of simplified guidelines, presented at the April Fly-In – while hailed at the time as much improved over the 1994 and 1997 guidelines – still includes the use of bullet points and counting elements of care. The House determined even that level of coding to be unacceptable, and subsequently, AMA has called for a halt to distribution of that simplified "new framework."

The House did, however, call for the AMA to continue to work in cooperation with organized medicine, through the CPT Editorial Panel and with HCFA to develop simplified E&M documentation guidelines that are clinically relevant and realistic, and that do not require excessive physician compliance time or documentation in excess of that needed by good patient care. The House resolution on this subject further calls for:

- 1.) A "knowing and willful" standard of proof to apply penalties for errors in coding and billing or insufficient documentation;
 - 2.) Opposition to the use of the confidential medical record as an accounting document;
 - 3.) Urging HCFA to discontinue random prepayment audits of E&M claims and advocating that the agency instead conduct focused medical reviews of outlier physicians using an independent medical peer-review process;
 - 4.) Advocating that no penalties be assigned to physicians for one-level of disagreement in E&M coding;
 - 5.) Efforts to stop HCFA's practice of requiring payback of alleged overpayments before appeal remedies are exhausted; and
 - 6.) Seeking immunity from Medicare sanctions for physicians who are participating in pilot testing of new guidelines.
- As a reminder, HCFA's indefinite extension of the grace period to implement new guidelines remains in place; however, for now, physicians must continue to provide adequate and proper documentation of services, using either the 1994 or 1997 guidelines.

Sunbeam settlement

The AMA board, quick to accept its ultimate responsibility in the matter leading to the disputed trademark licensing agreement between Sunbeam and AMA, took decisive action to ensure that similar events would not be repeated. You may recall the AMA Board's decision that the August 1997 agreement was contrary to long-standing AMA practices and directed that AMA not go forward with the contract. Sunbeam subsequently filed suit and sought at least \$20 million in damages. The board called for a comprehensive investigation into what led to the Sunbeam agreement and an ad hoc com-



Dr. Abramowitz

continued on page 18

On the Web...

Map makes navigating easier

Editor's note: This new column will feature specific information about the OSMA Web site. Each month we'll feature a different aspect of the site so our members can become comfortable navigating through all the information.

Do you know where to find information about current health-care legislation? Are you looking for CME courses? Do you need to contact an OSMA/AMA Delegate or Alternate Delegate? The new site map function on the OSMA Web site will make navigating the site much easier for you.

We understand if you're new to the Internet, you may have had difficulties finding information – and the OSMA is interested in assisting you.

A site map is a visual overview of a site showing where all specific information can be located. The OSMA site map will not only give you directions, but will hyperlink you to pages throughout the site. You simply click on the information on the site map and will be directly linked to that information.

You will find the site map by clicking on the "Site Map" navigational button that appears on the left of your screen.

If you have problems, comments or suggestions for the OSMA Web site e-mail: Karen Kirk at ohiomed@osma.org or call at (800) 527-6762, Ext. 6754. ■

Take Action

The OSMA is in the process of collecting members' e-mail addresses. So far, we have only 130. Our goal is to be able to inform members of urgent information on the Web site by doing a blast e-mail to them. If there are physicians in your office who have not supplied the OSMA with an e-mail address, encourage them to do so. Send your e-mail address to: osmo@osma.org or fax (614) 527-6763.

SOME THINGS
change.



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SOME THINGS
don't.

AMA Report...

continued from page 16

mittee, appointed by the House of Delegates, confirmed the board's findings. The House accepted the committee's report.

On July 31, AMA and OSMA announced that a settlement arrangement had been reached. A two-week negotiating effort has resolved the matter with a settlement involving far less than the original sum. Under the terms of the settlement, the AMA has agreed to reimburse Sunbeam \$2 million for out-of-pocket expenses, including attorney fees, as was mandated by the original contract. Additionally, AMA will compensate Sunbeam \$7.9 million. This settlement resolves all existing differences between the two organizations, and now allows the AMA to continue to go forward with its mission to serve patients and protect the quality of medicine.

Contested elections

Thomas Reardon, MD, immediate past chair of the AMA board, won the first contested race for the office of president-elect in five years. In other elections, Randolph D. Smoak, Jr., MD was re-elected to the Board of Trustees and elected to serve as its chair. Additionally, Susan Hershberg Adelman, MD, (Michigan); William G. Plested, MD, (California) and Bruce A. Scott, MD, (Young Physician Trustee, Kentucky); and Jeffrey Towson (Student Trustee, Stanford Univ., CA) were elected to seats on the board. Nancy W. Dickey, MD, was installed as the AMA's first woman president.

New EVP introduced

The board is proud to welcome as our new Executive Vice President E. Ratcliffe Anderson, Jr., MD, who, prior to assuming this formidable position, was a past Surgeon General of the U.S. Air Force and has a distinguished medical career.

Managed-care campaign

The AMA has launched a campaign in coordination with state medical societies, including Ohio, to expose and correct abuses in managed-care contracts. The aim of the campaign is to persuade health plans to cease harmful practices that are not in the best interests of patient care and are unfair to physicians. ■

What will it take to keep you as a member?

Decreasing membership has become a problem for all associations, and the OSMA is no exception. Many of our county medical societies struggle to maintain their membership. In a health-care marketplace where physicians are receiving lower and lower reimbursement, more and more of us are questioning the value of our dues dollars.



Lance Tolmage, MD

Solutions have been suggested. In May, the House of Delegates considered a resolution to de-unify the membership link between the county medical societies and the OSMA. The House rejected the resolution and recently Councilors agreed to uphold the House's decision when a proposal for a similar pilot program was submitted by the Academy of Medicine of Cleveland (AMC). In an effort to boost its membership, the AMC proposed allowing members to choose to join the county or the state medical association. The Council felt it had to reject any model that proposed action directly opposed to House of Delegates policy. But we heard the cry for help.

We strive to be sensitive to membership issues. We are concerned about all county societies and the problems they are experiencing with decreasing membership. We pledge ourselves, as OSMA's officers and leaders, to work with county societies to improve their membership numbers.

However, we believe that offering lower dues is not the best solution to this problem. If we are to justify our dues, we should point out to members and nonmembers the services we already offer. The Physician-Health Plan Partnership Act is a good example of how the benefit derived more than justifies the money spent on membership dues. Thanks to the work of your association, this new law will bring you greater freedom to practice the kind of

President's Perspectives

quality medicine you want to practice. Another example is our contract review service. It surprises me how many members are unaware of this important benefit. Before you sign a contract with a new or current carrier, call the OSMA's Division of Legal Affairs and ask for a review of the carrier's contract. It may save you from some legal nightmares. This fall, the OSMA's Ombudsman Services Department is offering presentations to help you understand the proposed documentation requirements for E&M guidelines. No matter what form these requirements eventually take, the truth is, we will need to document somehow. These seminars will help.

All of us need to work one-on-one to let nonmembers and even current members know that the money they spend on dues is returned to them in a wealth of services and benefits, not only on the OSMA level but from their county society as well.

We're not content to rest on our laurels, however. The OSMA realizes that services are necessary to maintain a sound membership base, and we want to be proactive in this area. If there is a service or a benefit that we don't currently offer and you think we should — let us know. We value your input. Contact your district councilor. Or call Doug Evans, director, Division of Membership Services, and let him know. His number is (800) 766-6762, Ext. 6774, e-mail: devans@osma.org. You can even post your suggestion on the Bulletin Board at the OSMA's Web site, www.osma.org. Councilors check the site regularly.

More important, we value your membership. This is your association. We want to hear from you. Let us know what it will take to keep you as a member. ■

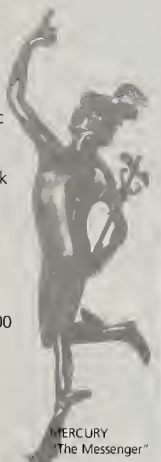
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Practice Tips

Anthem's rural Medicare pull-out creates stir

When Anthem decided to pull its Medicare HMO product out of 22 rural Ohio counties, seniors were not the only ones concerned over the move.

Richard Ruppert, MD, an OSMA member and retired physician, has secondhand experience with the problems caused by Anthem's decision to pull its Medicare HMOs out of rural Ohio. "My sister's coverage through Anthem has been canceled because she resides in Warren County, yet she receives care in Dayton where Anthem will honor its Senior Advantage Program," says Dr. Ruppert from his home in Toledo.

Dr. Ruppert believes HMO coverage for Medicare patients should be an option for all seniors. "The issues should be coverage for all, not bigger profits (for insurers)," he claims.

Anthem says the issue is not a matter of profits, simply a business decision that had to be made. "Anthem is unwilling to significantly reduce benefits and, thus, offer members a less comprehensive product than they're now receiving," says Lynn Gross, Anthem vice president. "At the same time, we can't continue to suffer financial losses on this product." Lower federal Medicare reimbursement, says Gross, has forced Anthem to make a difficult business decision.

Dr. Ruppert remains unconvinced, however, that Anthem's decision is for the best. He has outlined his concerns in a letter to Sens. Glenn and DeWine. If Anthem's withdrawal is not halted, he writes, "all rural Ohio is in jeopardy of all HMOs taking the same approach." He points out that many citizens move from urban to more rural settings to improve their cost of living and/or lifestyle.

As their residential zip code changes, so does their eligibility for coverage, even though many still receive their health care from hospitals and physicians located in zip code areas still covered.

Among the suggestions Dr. Ruppert has passed on to Sens. Glenn and DeWine: Change the eligibility coverage area from the patient's zip code to that of the provider; and review Medicare's reimbursement rates as they vary from county to county and adjust them to fit the needs of all.

Other Ohio physicians have voiced concerns over Anthem's Medicare HMO pull out as well, says Jennifer Hyle, OSMA Department of Ombudsman Services. "Almost as soon as the announcement was made, we received calls."

Meanwhile, politicians are asking federal and state agencies to address the repercussions felt by patients and providers alike. At Gov. Voinovich's request, the Ohio Department of Aging is helping seniors cope with the pull out.

"Our point of view is to look at the issue and come up with possible recommendations to alleviate this situation from happening again," says ODA's Chief of Communications Randy Leffler. The Medicare Task Force, originally established to help seniors make educated choices regarding the upcoming Medicare Plus Choice Program, is also trying to help "ease the transition process," says Leffler. Anthem representatives attended the last task force meeting. Presently, ODA is refining plans for educational programs where seniors can explore their medical coverage options. Leffler adds that ODA is also working with people who work with seniors, senior centers' staff, and social service and community organizations as a way of reaching a larger audience.

In conjunction with the Ohio Depart-

ment of Insurance (ODI), ODA also oversees the Ohio Senior Health Insurance Information Program (OSHIP) which provides assistance to seniors. However, ODI has no legal authority to require any insurer to offer coverage within a specified area. In an effort to ease the crisis, U.S. Rep. Rob Portman has asked the House Ways and Means Committee to urge HCFA to help find other Medicare HMO options for the affected rural areas.

Currently, six counties have no comparable alternate coverage being offered by other insurers. These include Brown, Darke, Green, Miami, Preble and Shelby counties. Anthem will offer four of their 10 Medicare Supplemental Standard Plans with no underwriting in these six counties. Yet each of these options will cost residents \$60 or more per month, representing an increase over the Senior Advantage program they presently carry.

— Pamela J. Willis

Take Action

Physicians, patients and staff can call the Ohio Department of Aging at (800) 282-1206 for more information on programs planned to educate seniors about their insurance options. OSHIP, the ODI program, is also willing to make a small supply of booklets—featuring information about the program—available to OSMA members to put in their offices. To order a supply, or for more information about the program, call OSHIP's toll-free number, (800) 686-2578. Finally, the National Medicare Hotline (800) 638-6833 also provides local/regional phone numbers for Health Insurance Information Counseling and Assistance Programs in individual areas.

How your practice can save \$100,000

Want to know what business and management techniques can help your practice save or recover \$100,000? How about some techniques and tools that will help you determine the costs of providing services...or deal with difficult employees?

Beginning in November, the OSMA will offer practice management courses designed to provide you with the newest information on how to manage your practice more effectively and efficiently. The workshops will be presented through Adams & Associates, a health-care consulting firm. Locations are not yet finalized.

November

The \$100,000 Office Manager
In this full-day workshop, you'll review the basics of managing the medical practice, ensuring revenue enhancement, and reducing overhead and unnecessary spending. You'll be provided with business and management techniques that can help you save or recover \$100,000 for your practice through better accounts receivable administration and efficient overhead management.

December

Managing practice expenses and determining cost of services
This half-day workshop addresses the importance of prudent overhead management and reducing expenses. You'll learn techniques and tools to help you determine the cost of providing services.

January

Personnel management
This full-day workshop has been designed to help managers and physicians resolve many of the problems of the day-to-day demands of overseeing the practice, and to provide more time for attending to those responsibilities that make the staff more efficient.

Watch for full details in future issues of *Ohio Medicine*. ■

Anthem offers to ease repayment process

As a result of a meeting between the OSMa and Anthem Blue Cross/Blue Shield, Anthem has agreed to make some concessions with regard to its request that physicians refund overpayments made to them.

Anthem sent letters to some Ohio physicians, requesting them to repay overpayments they received from Anthem. The letter angered the doctors and prompted a quick response from OSMa President Lance A. Talmage, MD, who said that the delay in seeking the refunds causes "an unreasonable burden on physician office systems, their income tax filing requirements, and necessary time for office billing staff to reconcile the individual accounts."

In a response, sent to the association by Anthem Executive Director Mark Isett, "Anthem is very eager to work with OSMa and its members to ease this process..."

Isett then offers two suggestions:

- If any physician wants written confirmation from Anthem, summarizing the refund, he or she may call their contact person. (See Anthem's letter to you describing the refund for the name of your contact person.)

- An extended time period for repaying the money will be afforded any physician for whom the recovery amount can't be paid in 30 days because it creates a financial hardship or time is needed to verify the refund. Again, the physician should work with the contact person identified in the letter. ■

Take Action

If you have further questions about this matter, contact Bill Fry, director, OSMa Ombudsman Services, (800) 766-6762, Ext. 6760.

From HOME REMEDIES To HMOs



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Dedicated To Your Success

New AMA guide gives tips on home-health care

Does your patient meet Medicare's criteria for homebound care? With the Office of the Inspector General focusing new attention on home health-care fraud and abuse, many physicians have become cautious about referring their patients to home health-care agencies.

The American Medical Association may be able to help. Its new booklet, *Medical Management of the Home Care Patient: Guidelines for Physicians*, tells what doctors need to know about:

- patient assessment;
- creation of a proper treatment plan;
- how to assess and work effectively with a home health-care agency;
- when house calls are appropriate.

As Ohio's population ages, more physicians will be forced to deal with

this issue. AMA's new guide provides clear, constructive advice that will protect both you and your homebound patient. ■

Take Action

For a copy of *Medical Management of the Home Care Patient: Guidelines for Physicians*, write to the AMA Department of Geriatric Health, 515 North State St., Chicago, IL, 60610, or call (312) 464-5085. If you are an AMA member, you are entitled to one free copy. Additional copies, or individual copies for nonmembers are \$4 each. The guidelines are also available in bulk at \$75 for 25 copies.

Didn't cash your BWC refund? It's too late now

If you haven't cashed the refund check sent to you by the Bureau of Workers' Compensation (BWC), it's too late. The checks are void after Sept. 1.

Rebates, totaling \$2.1 billion, were sent to employers in June after the agency decided to pass on savings on premium costs. One month later, however, there was still \$67 million worth of outstanding checks.

According to bureau officials, employers didn't cash checks because they:

- Didn't believe the checks were valid.

- Thought the checks were a scam and some called the Better Business Bureau to complain.

- Threw their checks away because that's what they do with all BWC mail.

More than 200,000 employers received the refunds. In many cases, these amounted to 120% of premiums. About 100 companies have asked the BWC to cancel their checks and reissue new ones. ■

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Medical Protective Company bought

Medical Protective Company has been acquired by GE Capital, a wholly-owned subsidiary of the General Electric Company.

The name Medical Protective Company will remain the same and will be managed through GE Capital's Employers Reinsurance Corporation (ERG). ERG has an A.M. Best rating of A++ and a Standard & Poor rating of AAA. (Watch future issues of *Ohio Medicine* for details of how to obtain our quarterly reports that provide the ratings of the top 10 professional liability companies in Ohio.) ■

Ohio Medicine

A Publication of the Ohio State Medical Association

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How to prepare for E&M audit

The OSMA is offering a new seminar, "Documenting, Coding and Auditing the Evaluation & Management Services," presented by certified coder Jillian Phillips, MA, CCS-P, CPC.

The seminars will provide a comprehensive look at the E&M codes and their modifiers, with emphasis on proper code selection based on the old, new and (projected) revised documentation guidelines. You will receive instruction on how to perform your own audits, as well as for compliance self-monitoring. Reference materials will include the OSMA Physicians' Self-Audit Kit.

Cost to members and/or their staff is \$100. Nonmember cost is \$185.

Mansfield/Thurs., Oct. 1 – Comfort Inn, 500 North Trimble Road

Columbus/Fri., Oct. 2 – OSMA Headquarters, 3401 Mill Run Drive, Hilliard

Chillicothe/Thurs., Oct. 8 – Christopher Conference Center, US Rt. 23 and 35, 30 North Plaza Blvd.

Cambridge/Fri., Oct. 9 – Holiday Inn, 2248 Southgate Parkway

Lima/Tues., Oct. 13 – Holiday Inn, 1920 Roschman Ave.

Toledo/Wed., Oct. 14 – Holiday Inn French Quarter, 10630 Fremont Pike, Perrysburg

Dayton/Tues., Oct. 20 – Dayton Marriott, 1414 Patterson Blvd.

Cincinnati/Wed., Oct. 21 – Radisson Hotel Cincinnati, 11320 Chester Road

Cleveland/Tues., Oct. 27 – Sheraton City Center, 777 St. Clair Ave.

Boardman/Wed., Oct. 28 – Holiday Inn Boardman, 7410 South Ave.

Take Action

To register, contact Cathy Sonnhaller, OSMA Department of Ombudsman Services, (800) 766-6762, Ext. 6759.

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Ohio Medicine

A Publication of the Ohio State Medical Association

4

Prompt payment of insurance claims continues to vex Ohio physicians, despite decades-old prompt pay law. The OSMA is monitoring this growing concern.

8

Management of chronic pain is the subject of the first live telecast to be co-sponsored by the OSMA and the OSU Medical Center for OMEN/OMEN-TV. Category 1 CME credit is available. It airs Oct. 23.



10

Supreme Court races may be the most important elections for medicine this November. Here are the candidates, and where they stand on issues like tort reform.

Insert

How does your malpractice insurance carrier rate? The OSMA has prepared a chart that tells you how 21 insurers writing the "highest premium volume" in the state rate with three prestigious rating services. As per the House of Delegates' request, this chart will become a quarterly report in *Ohio Medicine*.

Check out the OSMA Store on the OSMA's Web site at www.osma.org

Is Aetna negotiating its contracts?

The OSMA has learned of one member who was able to successfully negotiate terms of his contract with Aetna. Could the OSMA's direct requests to Aetna have helped?

The OSMA is aware of at least one case where Aetna U.S. Healthcare has approved a provider contract that meets the physician's terms.

In a letter, Aetna informed Alliance Medical Specialists, Inc. that the group could "remain participating providers with Aetna U.S. Healthcare" until Dec. 31, 1998. Compensation on all products – including the HMO plan – was changed from capitation (Aetna's traditional term) to fee-for-service. "At the end of the year, we would be open to negotiations to continue your relationship with Aetna U.S. Healthcare," the letter concludes.

OSMA's efforts

The OSMA has tried since last December to persuade Aetna to negotiate with physicians on contracts, especially on capitation terms.

"According to our members, Aetna had taken a position that physicians must accept capitation as part of (Aetna's) HMO product, regardless of whether or not capitation worked in their offices," says Katrina English, JD, director of OSMA's Division of Legal Affairs. To make this situation worse, physicians couldn't opt out of the HMO product – Aetna's contract required that providers sign up for all Aetna's products.

The OSMA had asked Aetna to provide more information to physicians regarding payment terms, and to reconsider the appropriateness of capitation, at least for some physician offices, as well as the rate itself.

"To be fair," says English, "Aetna did tell us that it routinely negotiates

provider contracts with individual physicians." However, this is the first time the OSMA has seen a willingness by the carrier to negotiate its terms.

"We hope that our direct approach with Aetna, asking them to reconsider their position, as well as educating our members about Aetna's contracts has brought about this change," says English.

Alliance group took a stand

Andres Lao, MD, one of the members of the Alliance group and an OSMA member, decided to take action similar to that taken by a group of obstetricians-gynecologists in Cincinnati.

"We sent a letter to Aetna telling them we were not going to renew our contract," says Carol Ritchie, the Alliance group's administrator. The letter explained that Aetna's policy requiring providers to sign up for all products

continued on page 3

Ohio's managed-care reform law effective Oct. 1

This month, Ohio's new managed-care reform law becomes effective. Do you know how the new law will affect you and your patients?

Managed-care reform is finally here. Do you know what your rights are?

On Oct. 1, the Physician-Health Plan Partnership Act (PHPPA) becomes law. This new law is a major step forward in helping to place the care of your patients back in your hands. If you don't yet know about this comprehensive managed-care reform bill, developed by the OSMA and Kaiser Permanente, it's not too late to learn how

you – and your patients – benefit under the new law.

All year, the OSMA has worked hard to get word of the importance of this bill to you – through *Ohio Medicine*, the Web site, and, in August and again last month, through special mailings. Also in September, information

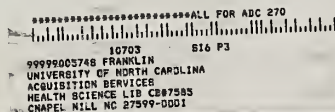
about the new law's benefits was sent to members of the media and also to legislators.

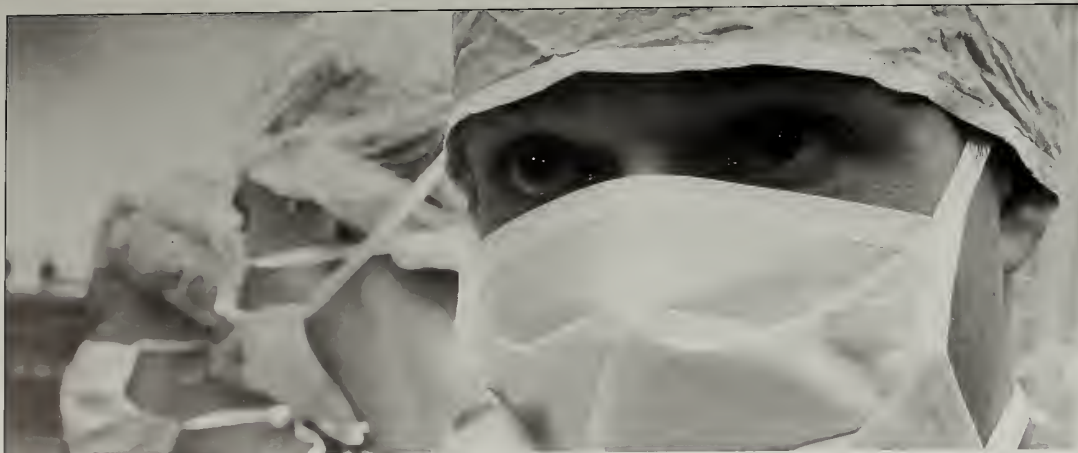
One legislator, however, already understands the impact the new law will have on Ohio health care. Rep. Dale

continued on page 3



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Aetna...

was not in the practice's best interests. Shortly after the letter was sent Ritchie received a phone call. "They asked us if we would consider signing if the reimbursement method was changed to fee-for-service (from capitation)." Ritchie told Aetna to put its offer in writing.

Ritchie says she is not surprised that Aetna decided to deal with Alliance Medical Specialties, Inc. "We're the dominant group in the community," she says. "I think our action caused them concern."

Negotiations are more likely to take place in those areas of the state where

continued from page 1

Aetna's provider network is thin. Where there is a large concentration of physicians, such as in the state's urban areas, there has been no indication that Aetna is negotiating terms with providers. ■

Take Action

If you have had your terms met by Aetna, the OSMA would like to know. Contact the OSMA's Division of Legal Affairs, (800) 766-6762; fax, (800) 766-6763; e-mail: legal@osma.org

Managed care...

continued from page 1

Van Vyven, (R-Sharonville), chair of the House Health Committee and sponsor of PHPPA says: "The best thing about this law, from my perspective, is that it puts physicians back in charge of making medical treatment decisions." Then he adds, "The leadership of OSMA was instrumental in making this national model of managed-care reform legislation a reality in Ohio."

By now, you should be aware of the law's benefits:

- standardized credentialing;
- UR decision appeals reviewed by a clinical peer;
- your right to participate in a performance improvement plan if a plan is terminating your contract for "quality reasons";
- prohibition against health plans denying reimbursement for a pre-authorized treatment for an eligible enrollee.

These are just a few of the law's provisions. Some will require you to make amendments to your existing managed-care contracts.

Do you know your new rights? Do your patients know what benefits they will gain now that the law has become effective? If not, see "Take Action". If you are aware, however, of just what kind of improvement PHPPA will make to the quality of your practice,

and the practice of all Ohio physicians, then tell a colleague. Tell members how effective their dues dollars are. And tell nonmembers that this is what organized medicine can do. But tell them such victories don't come cheaply or easily. We need their help to continue improving health care for Ohioans. Invite them to become a member of the OSMA team. ■

Take Action

If you have not yet received your mailings that allow you to send for information regarding contract checklists and information on your right to appeal, or for tent cards that allow you to inform your patients about the new law, contact OSMA's Division of Public Affairs, (800) 766-6762.



Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.

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Resolution report:

Prompt pay issue continues to plague physicians

In May, the OSMA House of Delegates passed Resolution 17-98 which addresses the issue of prompt payment of insurance claims, a problem that has vexed Ohio physicians for years, despite a "prompt pay law" that passed the Legislature over a decade ago.

According to the OSMA resolution, the association is to work with the Ohio Department of Insurance (ODI) to see that the law is enforced. If the law's provisions are not implemented by June 1999, the resolution calls for the OSMA to consider litigation, "including a class-action lawsuit against the ODI and other appropriate state enforcement agencies" as needed.

That's tough language, but reflects the frustration of Ohio physicians like Paul Vanek, MD, of Mentor who has waited a year for most of his Qualchoice Health Plan claims to be paid. He says when he left a local physician-hospital organization (PHO) last year for private practice, he assumed the 21-day reimbursement turnaround between Qualchoice and the PHO would follow. It did not. "Every single one of my Qualchoice claims were very significantly delayed," he says. Although current claims are repaid in a "reasonable time frame," Dr. Vanek says he still hasn't received payments for all the claims he made last year. "Some celebrated their birthdays in the last few weeks," he says.

And Dr. Vanek is not alone in his frustration. Bill Fry, director of OSMA's Ombudsman Services department, says he receives call after call from members about poor service by payors - including long delays in reimbursements. The trouble, according to

Fry, is that Ohio's prompt pay law does not apply to all insurance carriers in Ohio and the current law has no teeth. Even though the law says insurance companies must pay clean claims within 24 days of receiving them, for example, it also allows insurance companies to stipulate longer pay delays in their contracts with participating providers. If you sign contracts that say reimbursement will occur in 60 or 90 days, you negate the 24-day time frame provided by law. (The OSMA offers a contract review service that advises members about these provisions in third-party contracts. See "Take Action" for information on how to take advantage of the OSMA's contract review service.)

The OSMA is working on several fronts to monitor this important concern. In addition to reviewing how other states have handled this problem (see related story), the OSMA is also working with the ODI to clear up the definition of a "clean claim" as well as the process for providers to initiate a complaint. Recently, the ODI sent to the OSMA for comment a thick form it had drafted which, when completed by physicians, would launch an investigation into late payments. "The form was too long and cumbersome," says Carol Mullinax, director, Division of Public Affairs. So the ODI is back at the drawing board, attempting to streamline the process.

Another problem is that the ODI was not committed to using the information in the forms to resolve problems being experienced by individual physicians, but only to track trends and attempt to address those.

Meanwhile, the OSMA is also de-

ciding whether or not additional legislation on this subject should be introduced. "If the current law on prompt pay can't be enforced, we may talk to legislators about introducing a new bill with stronger enforcement provisions," says Krista Bistline, Department of Legislation. Before that can be done, however, the OSMA needs to hear from you. "We need to know the extent of the problem, how widespread is it?" says Bistline. If you've had trouble with reimbursements, call and let her know. (See "Take Action" below.)

In brief, the OSMA is aware of the growing problem of late payments to physicians and is taking steps toward ensuring that provider claims are paid promptly - within the time frame stipulated by law or third-party contracts.

Ohio Medicine will continue to provide you with information on this topic. - Jan Alloy

Take Action

If you would like more information about the OSMA's contract review service, contact the Division of Legal Affairs, (800) 766-6762. If you have a prompt pay issue to report, contact Krista Bistline, Department of Legislation, (800) 766-6762, Ext. 6748. If you would like help resolving trouble with slow reimbursements, contact Bill Fry, Department of Ombudsman Services, (800) 766-6762, Ext. 6760. You may also order a copy of the OSMA brochure, "When all else fails: How to file a complaint with the Ohio Department of Insurance" by calling the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580. Ask for Item #33-98.

Other states prompt pay laws

Prompt payment laws vary throughout the country. Georgia, Massachusetts and Arkansas require immediate payment. Georgia charges a penalty of 18% interest per year. Here is a sample of other states' laws:

• **Kentucky.** Payment within 30 days, penalty of 12% annual interest and attorney's fees.



• **Michigan.** Payment within 30 days or 12% annual interest beginning at 60 days.

• **Texas.**

Payment within 45 days or subject to an 18% annual interest penalty and attorney's fees.



• **New York.** Payment within 45 days or subject to a fine of \$500 a day, in addition to 12% annual interest.

• **Oklahoma.** Payment within 30 days; after 60 days, assessment of interest of 2 percentage points above previous year's average United States Treasury Bill rate.

• **West Virginia.** Notice within 15 days of acceptance or denial; additional notice every 30 days if insurer needs time to investigate claim; payment or settlement of all claims within 90 days subject to penalty of 1% above current prime interest rate. ■



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Medical Board OKs rule change for weight-loss drugs

Patients now have up to 12 weeks to lose weight on their therapy, but some doctors say that's not enough time.

The State Medical Board of Ohio has decided to allow patients more time to lose weight before their drug therapy is deemed a failure. In fact, doctors may re-prescribe the drug once the allotted time has expired – as long as the patient waits six months before resuming their diet regimens.

Prior to the board's new rule, the proposed rule used drug manufacturers' recommendations to set a limit on the length of the therapy. The problem was, none of these suggested lengths of treatment lasted longer than a few weeks. The new rule gives patients up to 12 weeks to lose weight on the therapy.

Medical Board Report

However, the patient must visit his or her physician every 30 days during the course of the treatment, and must be actually losing weight to continue the therapy.

For bariatric physicians, even the new rule is restrictive. They point out Ohio and Mississippi are the only two states where doctors are regulated strictly on prescribing diet drugs. They may draft a law in the future that allows doctors more freedom when prescribing diet drugs.

In the meantime, the board's new rule includes the following provisions:

- Sets a numerical definition of obesity using body-mass index. Under the new rule, doctors can only prescribe weight-loss drugs for those with a body-mass index of 27 if that person also suffers from hypertension or other health condition caused by obesity.

- Requires the patient to meet face-to-face with the doctor every time a weight-loss drug prescription is renewed.

- While the patient may have up to 12 weeks on weight-loss drugs, he or she must demonstrate proof of weight loss within a 30-day period. That's expanded from the board's original rule which proposed that weight loss be demonstrated in a 14-day period.

- Doctors will be prohibited from re-prescribing diet drugs for any patient who has abused the drug, sold it or given it away. However, patients

who have reached the 12-week limit may be re-prescribed the weight-loss drug after a waiting period of six months.

- Any diet-drug that is approved for long-term use by the Food and Drug Administration (such as Meridia), may be prescribed on a long-term basis as long as the following requirements are met:

- The patient has a body-mass index of at least 35;

- Another dangerous health condition is present;

- The patient has lost at least 5% of his or her weight before the drug treatment began; and

- Weight loss of at least 5% is maintained, with weight measurements to be taken at 30-day intervals. ■

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Quick news

New bills introduced...House Bill 788, sponsored by Rep. Pat Tiberi (R-Columbus), establishes a committee to review denials of adaptive equipment for certain Medicaid recipients; House Bill 810, sponsored by Rep. David Hartley (D-Springfield) would prohibit the sale of health-care records; and House Bill 812, sponsored by Rep. J. Kirk Schuring (R-Canton) proposes to revise the laws that pertain to chiropractic practice. Watch for more news on these bills in future issues of *Ohio Medicine*.

CHIP expansion recommended...The task force examining whether to further expand health-care coverage for Ohio's uninsured has recommended the state provide insurance to children in families whose income level falls between 150%-200% of the poverty level. The task force also recommended: Providing well-child check-ups and immunizations; preservation of the private sector insurance market for those who have access; monitoring the quality of care children receive through the CHIP II program; and strengthening public oversight and participation in the plan.

Trauma data revealed...No action is expected until next year on the bill that mandates a statewide trauma system, but both sides now have some data to ponder. A state survey, sent to 182 acute-care hospitals in 1997, shows that: Nearly every hospital provides emergency services; about 1 million patients are treated for critical injuries (including about 270,000 16 years and younger); 137 have helicopter landing sites at the hospital; 26 have separate trauma services; 109 have structured protocols to speed trauma patients to trauma centers; and 17 hospitals treat "major" pediatric trauma patients. The statewide trauma bill is expected to be reintroduced next year.

Dateline Ohio

Verification service speeds licenses to some

Since last November, applicants for Ohio medical licenses have been part of a program piloted by the State Medical Board of Ohio.

The program, known as the Federation Credentials Verification Service (FCVS), was developed by the Federation of State Medical Boards to streamline the credentials verification process. Joan Wehrle, the medical board's special assistant to the director, explains that FCVS compiles and maintains a portfolio of primary-source, verified core credentials. The service reduces the redundant paper chase encountered each time a physician applies for a medical license in a different state, says Wehrle. With the applicant's core credentials material collected and verified by FCVS personnel, the medical board can focus its resources on the license application and the inquiry responses.

Still a wait for new license

Still, processing initial license applications is a 10- to 12-week process, with or without the benefit of FCVS.

Digital TV may interfere with hospital medical equipment

Digital television is creating some unexpected concerns for health-care providers. And the problem has now reached Ohio.

Fifty-two TV stations across the state have been allocated channels for DTV, and already one Central Ohio television station has received permission to begin digital television operations. As a requirement of the Federal Communications Commission, the Columbus station notified all Central

That's a time frame that some applicants, especially new ones, don't anticipate, says Kate Hunter, OSMA Division of Legal Affairs. "About July every year, we begin to receive calls from new doctors who are to begin their training programs and have not yet received their medical license."

Often, that's because the new medical graduate didn't begin the application process early enough. "Students shouldn't wait until after graduation to turn in their license applications if they expect to start a training program the next month," says Hunter.

Wehrle agrees that FCVS may not significantly hasten the initial application process. Where the service will be helpful, she says, is in expediting license applications from physicians already licensed in another state.

"For example, if an out-of-state physician with an established FCVS portfolio applies for a license in Ohio, FCVS forwards the portfolio information to the medical board, often within two weeks. Once the Ohio background check is completed and the application

is approved, an Ohio license can be issued, Wehrle says.

The service should be especially helpful for International Medical Graduates, says Wehrle. Typically, verifying overseas credentials and obtaining document translations involves a long delay, she explains.

Rough transition

The service has not been without a downside. The board's transition from using its own staff to using the service to verify credentials has not always been smooth. "Ohio was the first large state to adopt the FCVS," says Wehrle, "despite assurances, I'm not sure they were ready for us."

Wehrle recalls that in July 1997, the average time to complete the FCVS verification process was 104 days. That has since been significantly shortened to about 60 days, says Wehrle.

Ohio had also decided to mandate that all of its license applicants go through the FCVS process. That's about 100 applications a month, she says. "We believed that an exclusive prospective approach to the FCVS was necessary. Optional participation approaches by other entities had failed in the past." However, Ohio is only one of a handful of states that require use of the service. "Currently, there are 41 licensing jurisdictions accepting FCVS," says Wehrle.

Once licensing boards see how simple and quick credential verification can be, more states are likely to accept the FCVS, she says.

"I look for all licensing jurisdictions to accept FCVS eventually," Wehrle continues. "Even those states where current statutes prevent them from using the service are looking to change their laws." ■

Medical and Osteopathic Licensing Boards that Accept the FCVS Physician Information Profile

Alabama
Arizona Medical
Arizona Osteo
California Medical
Colorado
Delaware
Florida Medical
Georgia
Guam
Hawaii Medical
Idaho
Indiana
Kentucky
Louisiana
Maine Medical
Maryland
Massachusetts
Michigan Medical
Michigan Osteo
Minnesota
Missouri
Montana
Nevada Medical
New Hampshire¹
New Jersey
New Mexico Medical
North Dakota
Ohio¹
Oklahoma Medical
Oklahoma Osteo
Oregon
Rhode Island
Utah¹
Tennessee Medical
Texas (U.S. grads only)
Vermont Medical
Vermont Osteo
Virginia
Washington Medical
Washington Osteo
Wyoming

¹ Requires FCVS Profile for all applicants for licensure

OMEN pain presentation features OSMA members

The OSMA and the Ohio State University Medical Center have teamed together to offer a live program entitled "Management of Chronic Pain," featuring a presentation by OSMA members Constantino Benedetti, MD, and Mark



Boswell, MD, PhD. The Ohio State University's OMEN/ OMEN-TV (Ohio Medical Education Network) will broadcast the program live via satellite Friday, Oct. 23 from noon to 1 p.m. Following their presentations, phone lines will be open for questions from the audience.

Dr. Benedetti, professor of clinical anesthesiology at the OSU Medical Center and Dr. Boswell, chief of anesthesia pain services at University Hospitals of Cleveland, are members of the OSMA's Ad Hoc Committee on Pain Education. The committee is responsible for the chronic pain handbook.

"Management of Chronic Pain" and other OMEN programs are broadcast live to 70 hospitals and 75 other locations across the central and eastern time zones. Category 1 CME credit is available.

"The co-sponsoring of educational programs by the OSMA and OMEN is an opportunity that we feel with benefit the quality of CME offered by both organizations," says David Dawdy, MD, chair of the OSMA's Committee on Education. "We hope to work more with OMEN as part of many initiatives planned by the committee to expand the quality and quantity of education available to Ohio physicians." ■

Take Action

If you have questions about CME activities and OMEN, contact Janet Shaw, OSMA's Department of CME, (800) 766-6762, Ext. 6737.

OSMA Insurance Agency NEWS BULLETIN

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Fax: 216-292-8186

Premium Group

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Fax: 440-542-5005

CANTON

Sirak-Moore Insurance Agency
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Fax: 330-493-0642

CLEVELAND

Oswson Insurance Agency
Tel: 800-860-0090
Fax: 216-356-2126

United Agencies

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Fax: 216-696-3423

Jacob Venegal of Ohio

Tel: 216-642-5005
Fax: 216-642-5002

COLUMBUS

Insurance Offices of Central Ohio
Tel: 614-221-5471
Fax: 614-221-4776

The Ohsner Company

Tel: 614-488-5656
Fax: 614-488-5656

Grubers' Columbus Agency, Inc.

Tel: 614-486-0611
Fax: 614-486-0581

DEFIANCE

Stauffer Mendenhall Agency
Tel: 800-875-5431
Fax: 419-782-7940

KETTERING

Associated Insurance
Consultants, Inc.
Tel: 513-293-6000
Fax: 513-293-8070

LIMA

Stolly Insurance
Tel: 419-227-2570
Fax: 419-227-8743

MIOLETTOWN

Insurance Associates
Tel: 513-424-2481
Fax: 513-424-8351

TOLEDO

Palmer-Blair Insurance Agency
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Fax: 419-248-2129

WESTLAKE

Haas Insurance Agency
Tel: 216-871-8720
Fax: 216-871-8723

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Fax: 614-436-5406

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Indepth Report

Why the Supreme Court race may be the most important in November

While the Statehouse awaits the upcoming election so it can deal with the likes of nurses seeking prescriptive authority, legislation on a statewide trauma system, mental health parity, and managed care, the heart of medical reform may really have its focus in the Ohio Supreme Court races.

In November, three of the seven Court seats will be up for election, offering the possibility that the character of the Ohio Supreme Court could be changed significantly. The OSMA was a leading player in the successful enactment of tort-reform legislation two years ago, but it may lose this issue in the Court because certain judges don't agree with the "policy" of this important issue. Many suggest this is so because the current philosophical make-up of the Court can be characterized as "activist," where several justices have taken an activist stance, energetically disagreeing with policy and laws sanctioned by the Legislature. To many observers, the Ohio Supreme Court is taking inappropriate action in our constitutionally sanctioned system of checks and balances.

"The OSMA feels that the judicial branch of our government should interpret law, not make it," says OSMA Director of Legislation Tim Maglione, JD. "Thus, the upcoming election may be an opportunity to change the philosophical direction of the Court." While judicial races often are largely ignored in light of much more publicity-based campaigns, such as those for governor, their impact on professions like medicine can be profound.

With judicial contests tempered

against specific campaign promises of what candidates would do or why they would do it, the races can seem benign, but are far from it. Instead, qualification, experience, attitude and judicial philosophy become the focus. Just in the last few years, new causes of action in medical malpractice have been "created" by Court interpretations.

Additionally, Ohio's tort reform may be ruled unconstitutional by judges who disagree with the policy of civil justice reform. Getting familiar with candidates, their supporters and their likely viewpoints is essential for your informed vote. Also expect issues to arise from who or what organizations provide financial backing for the candidates. — *Yvonne Burry*

Chief Justice Race

Thomas J. Moyer vs. G. Gary Tyack

Chief Justice Thomas J. Moyer (R)

Viewpoint: In a wrongful death case where four justices expanded the statute of limitations, Justice Moyer dissented, saying, "The expansive holding adopted by the majority today could not be more illustrative of the harm effected upon our jurisprudence when the judiciary does not follow the principle that courts are ill suited and not designed to substitute their policy judgment for that clearly stated by the Legislature."

Training/Experience: Chief Justice, Ohio Supreme Court 1986-1998; Judge, 10th District Court of Appeals 1979-1986; alternated between private law practice and working in the Governor's Office 1966-1979; JD, The

Ohio State University.

Endorsements/Key Contributors: Small business; health-care groups; Ohio Society of Certified Public Accountants.

Candidate G. Gary Tyack (D)

Viewpoint: Having often stretched a minor issue into a major campaign issue, Tyack has been noted by the Ohio Chamber of Commerce survey of judicial candidates as ruling in a pro-business manner in only 13 of 36 judgments on cases such as employment, insurance and tort.

Training/Experience: Judge, Ohio 10th Court of Appeals, 1991-present; faculty, Ohio Judicial College; JD, The Ohio State University 1974.

Endorsements/Key Contributors: Ohio Academy of Trial Lawyers; OCSEA/AFSCME Local #11; Ohio AFL/CIO; OSUA-CAP Council.

Supreme Court Seat #1 Race

Francis Sweeney vs. Stephen W. Powell

Judge Francis Sweeney (D)

Viewpoint: His evaluations by the Ohio Chamber of Commerce survey show low business support judgments in about 30% of the cases on his docket.

Training/Experience: Justice, Ohio Supreme Court 1992 to present; Judge, Eighth Appellate District 1988-1992;

Candidates speak out on health care

While the Supreme Court races are important, so too is the race to determine who will succeed Gov. George Voinovich.

BOB TAFT (R)

Viewpoint on Health Care: Health insurance appeals in 14 days or 72 hours in life-threatening cases; expanding patient access to women's health services and emergency care, without preapproval; making health insurers legally and financially accountable for decisions that result in poor outcomes; increasing reserve requirements for new insurers, from \$1.5 million to \$5 million; creating a state-operated, toll-free consumer health insurance hot line.



Bob Taft (R)

Training/Experience: Ohio Secretary of State, two terms; Hamilton County Commissioner; Ohio House of Representatives; JD, University of Cincinnati Law School, 1976.

Endorsements/Key Contributors: Ohio Medical PAC; Ohio Troopers Coalition; Fraternal Order of Police; Ohio Society of Certified Public Accountants; Association of General Contractors; National Federation of Independent Business/Ohio; Teamsters Local Unions 294 and 37.

LEE FISHER (D)

Viewpoint on Health Care: Increased disclosure by insurance companies, new measure to combat fraud, and patient privacy protection; wants state health-care

continued on page 11

continued on page 11

Rating the professional liability insurance carriers

Nationally, despite a strong economy and rising financial markets, 23 insurance companies were taken over by state regulators in 1997, according to statistics compiled by Weiss Ratings, Inc., a leading provider of ratings and analyses on the insurance industry. In all, insurance company failures were up 200% from 1996, when only eight insurers failed.

Property and casualty (P&C) insurers, which provide coverage for homes, autos and businesses, suffered the greatest difficulties, according to Weiss. P&Cs accounted for 19 of the 23 national failures, due primarily to intense competitive pressures. This represents a tenfold increase from 1996, when only two P&C insurers were taken over by state regulators.

When Ohio-based PIE Mutual Insurance Company went out of business in late 1997, its assets were \$281.7 million. During 1996, PIE wrote 30.2% of the medical malpractice insurance coverage in Ohio, according to the Ohio Department of Insurance.

House of Delegates requests ratings

In response to this trend and its consequences, the following ratings chart of selected medical malpractice insurance companies conducting business in Ohio has been requested by the OSMA House of Delegates in Resolution 32-98: "Resolved, that the OSMA publish the ratings of professional liability insurance carriers operating in the state of Ohio at least quarterly, together with a detailed explanation of the meaning and significance of the assigned ratings, as a basic and timely service to members."

The Ohio Department of Insurance (ODI) reviews and licenses insurance companies that conduct business within the state. Should any of these licensed companies go into liquidation, their obligations will be met, with some limitations, by the Ohio Insurance Guaranty Association (OIGA). The OIGA does not cover unlicensed insurance companies, including surplus line companies, nor reciprocal and interinsurance exchange companies offering malpractice insurance. You can confirm the license status of any company by calling ODI at (614) 644-2647.

OSMA has chosen to use three highly-recognized rating services for the quarterly chart — A.M. Best Company, Standard & Poor's, and Weiss Ratings, Inc. Each rating service uses a multifaceted, proprietary system to analyze the health and strength of each company. According to Dan Kelso, president of the Ohio Insurance Institute (OII), "As thorough as rating reviews are, a well-rated company could still become insolvent quickly if, for instance, that company's management chooses to hide pertinent facts from regulators and rating services."

Check ratings frequently

Ratings can change at any time for many reasons; in addition, a company can be placed on a "watch" list by a rating service if a major change is anticipated within the company. Therefore, in conjunction with this quarterly chart, OSMA has provided hyperlinks to the most appropriate Web pages for the three rating services. You can access these from the OSMA Web site (www.osma.org) by using the "Links" button. You will need to be an OSMA member to access the link. Telephone numbers are also listed after the chart. These are easy ways for you to check the ratings for your own insurance company, or those you are considering, on a more frequent basis.

Rating services also offer research reports on individual companies for a fee; these may be ordered from their Web sites or by phone, and may also be available from the insurance company or through your insurance agency.

There is no charge for receiving verbal ratings with Standard & Poor's. However, the A.M. Best Company and Weiss Ratings, Inc., which rate only insurance companies, do charge for rating inquiries. Of the three, only Weiss does not charge the companies being rated. The modest inquiry fees are described in this insert and on their Web sites.

Based on 1997 ODI reports, 93 companies (licensed and unlicensed) wrote medical malpractice premiums in Ohio last year. OSMA has chosen to use "premium volume written in Ohio" as the most objective standard for selecting the insurance companies for this chart. The top 16 companies, cumulatively, wrote 88.6% of the medical malpractice premium volume in 1997, and, individually, had captured 1% to 19% of the market share.

Size and market share not keys to strength

Realistically, according to OII's Kelso, size and market share are not always indicative of strength, service, claims-paying ability or price. Consulting your insurance agent, researching current ratings and talking with other physicians regarding service will help to balance any inherent weaknesses of any single evaluation method.

Also included in this quarterly listing are those medical malpractice insurance companies that advertise in *Ohio Medicine*, or those represented by insurance agencies that advertise.

The ratings reported in the chart are reprinted with permission from the rating services indicated, and do not reflect OSMA's independent evaluation of the companies listed. — Carol Larimer

**Selected insurance companies
that write medical malpractice
insurance coverage in Ohio**

**NAIC
Code**

**A.M. Best
Rating**

**A.M. Best
Date**

**S&P
Rating**

**Weiss
Rating**

American International Insurance Co. **	32220	A++ g	8/98	AAA	B-
Chicago Insurance Co. *	22810	A p	5/98	BBq	B-
Cincinnati Insurance Co. (The)*	10677	A++ g	5/98	AA+	A
Continental Casualty Co., * member of CNA Insurance **	20443	A p	9/97	A+	C+
Doctors' Co., an Inter- insurance Exchange (The) * **	34495	A g	5/98	Aq	A-
Evanston Insurance Co. **	35378	A p	11/97	A	C-
Frontier Insurance Co. * **	34266	A- g	7/97	A+	C+
Gulf Insurance Co. *	22217	A+ p	6/98	AA	B
Health Care Indemnity Inc. *	35904	A-	2/98	BBBq	not rated
Kentucky Medical Ins. Co. * **	38105	A- r	8/98	A+	C
Medical Protective Co. * **	11843	A	11/97	AA	B-
Medical Inter-Insurance Exchange of NJ * **	34398	A	2/98	BBBq	B-
Mutual Assurance Inc. * **	33391	A g	6/98	A+	B
National Union Fire Insur- ance Co. of Pittsburgh, PA **	19445	A++ g	8/98	AAA	B+
OHIC Insurance Co. * **	35602	A-	4/98	A	C+
PHICO Insurance Co. * **	35718	A-	6/98	BBBq	C
ProNational Insurance Co. ** (a merger of PICOM Insurance Co. & PPTF, effective 7/98)	38954	A- g	3/98	A-	C

**Selected insurance companies
that write medical malpractice
insurance coverage in Ohio**

	NAIC Code	A.M. Best Rating	A.M. Best Date	S&P Rating	Weiss Rating
St. Paul Fire & Marine Insurance Co. * **	24767	A+ p	1/98	AA	B+
St. Paul Mercury Insurance Co. * **	24791	A+ r	1/98	AA	B
Transportation Insurance Co. *	20494	A p	9/97	A+	C+
Zurich American Insurance Co. of IL **	27855	A+ p	9/98	AA-	C+

* : a company that is one of the 16 top-ranked Ohio medical malpractice insurance companies by dollar value of Ohio premiums written in 1997. Source: Ohio Department of Insurance

** : an *Ohio Medicine* advertiser, or, a company represented by an insurance agency that is an *Ohio Medicine* advertiser (as reported by that agency)

Best's Ratings are under continuous review and subject to change and/or affirmation. For the latest Best's Ratings and company reports (which include Best's Ratings) visit Best's Web site at www.ambest.com/bestline/sales/ratings.html. See Guide to Best's Ratings for explanation of use and charges.

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Weiss Safety Ratings

Weiss Ratings, Inc., is the only independent rating agency covering the insurance industry. It also updates ratings quarterly. Unlike the other rating agencies, Weiss accepts no compensation from the companies it rates, and does not permit companies to suppress unfavorable ratings; all ratings are published, good or bad. Weiss prides itself on a record of providing ratings that are accurate, that give early warning of financial vulnerability, and that reflect early improvements in financial health. Furthermore, the Weiss Safety Rating scale is very easy to understand.

Weiss Safety Rating Scale

A = Excellent; B = Good; C = Fair; D = Weak; E = Very Weak; F = Failed

What Our Ratings Mean

A Excellent. The company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, we believe that this company has the resources necessary to deal with severe economic conditions.

B Good. The company offers good financial security and has the resources to deal with a variety of adverse economic conditions. It comfortably exceeds the minimum levels for all of our rating criteria and is likely to remain healthy for the near future. However, in the event of a severe recession or major financial crisis, we feel that this assessment should be reviewed to make sure that the firm is still maintaining adequate financial strength.

C Fair. The company offers fair financial security and is currently stable. But during an economic downturn or other financial pressures, we feel it may encounter difficulties in maintaining its financial stability.

D Weak. The company currently demonstrates what we consider to be significant weaknesses which could negatively impact policyholders. In an unfavorable economic environment, these weaknesses could be magnified.

E Very Weak. The company currently demonstrates what we consider to be significant weaknesses and has also failed some of the basic tests that we use to identify fiscal stability. Therefore, even in a favorable economic environment, it is our opinion that policyholders could incur significant risks.

F Failed. The company is under the supervision of state insurance commissioners.

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Weiss Safety Ratings are available by phone only, using a major credit card: \$15 for one company; \$36 for three. Call-in hours are Mon.-Fri.: 8:30 a.m. to 10:30 p.m.; Sat.: 9 a.m. to 5 p.m. Call (800) 289-9222 for ratings.

To obtain insurance company ratings and related information:

A.M. Best Company

order a rating: secure site, requires a credit card:

www.ambest.com/bestline/sales/ratings.html

order a company profile: secure site, requires a credit card:

www.ambest.com/bestline/sales/reports.html

ratings with credit card: (908) 439-2200,

Ext. 5742

Standard & Poor's

home page: www.ratings.com

link to ratings pages:

www.ratings.com/insurance/index.htm

verbal ratings: (212) 208-1527, Ext. 1

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CURRENT GUIDE TO BEST'S RATINGS

March 30, 1998

For a complete explanation of Best's Ratings, please refer to the Preface of *Best's Insurance Reports®* or *Best's Key Rating Guide®*. Best's Ratings reflect our independent opinion, but are not a warranty of a company's financial strength and ability to meet its obligations to policyholders.

BEST'S RATINGS AND FINANCIAL PERFORMANCE RATINGS (FPR)

A.M. Best assigns to insurance companies one of two types of rating opinions, a Best's Rating (A++ to F) or a Financial Performance Rating (9 to 1). The Best's Rating represents an opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance and market profile. The FPR represents an opinion based primarily on a quantitative evaluation of a company's financial strength and operating performance. Best's Ratings and FPRs provide an independent opinion of an insurance company's ability to meet its obligations to policyholders. For additional information, refer to the Preface.

Secure Best's Ratings

A++ and A+ Superior
A and A- Excellent
B++ and B+ Very Good

Vulnerable Best's Ratings

B and B- Fair
C++ and C+ Marginal
C and C- Weak
D Poor

E Under Regulatory Supervision
F In Liquidation
S Rating Suspended

Secure FPR Ratings

FPR 9 Very Strong
FPR 8 and 7 Strong
FPR 6 and 5 Good

Vulnerable FPR Ratings

FPR 4 Fair
FPR 3 Marginal
FPR 2 Weak
FPR 1 Poor

RATING MODIFIERS

Rating Modifiers are assigned to Best's Ratings and Financial Performance Ratings to identify companies whose rating opinions are Under Review (u) and may be subject to near-term change; or are based on a Group (g), Pooling (p) or Reinsurance (r) affiliation with other insurers. For additional information, refer to the Preface.

g - Group
p - Pooled

r - Reinsured
u - Under Review

NOT RATED CATEGORIES (NR)

Companies not assigned a Best's Rating or FPR are assigned to one of five NR categories which identifies the primary reason a rating opinion was not assigned to the company. For additional information, refer to the Preface.

NR-1 Insufficient Data
NR-2 Insufficient Size and/or Operating Experience
NR-3 Rating Procedure Inapplicable

NR-4 Company Request
NR-5 Not Formally Followed

FINANCIAL SIZE CATEGORIES (FSC)

Assigned to all companies and reflects their size based on their capital, surplus and conditional reserve funds in millions of U.S. dollars, using the scale below. For additional information, refer to the Preface.

FSC I less than 1	FSC V 10 to 25	FSC IX 250 to 500	FSC XIII 1,250 to 1,500
FSC II 1 to 2	FSC VI 25 to 50	FSC X 500 to 750	FSC XIV 1,500 to 2,000
FSC III 2 to 5	FSC VII 50 to 100	FSC XI 750 to 1,000	FSC XV greater than 2,000
FSC IV 5 to 10	FSC VIII 100 to 250	FSC XII 1,000 to 1,250	

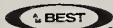
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The Insurance Information Source

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A Standard & Poor's Insurer Financial Strength Rating is a current opinion of the financial security characteristics of an insurance organization with respect to its ability to pay under its insurance policies and contracts in accordance with their terms. This opinion is not specific to any particular policy or contract, nor does it address the suitability of a particular policy or contract for a specific purpose or purchaser. Furthermore, the opinion does not take into account deductibles, surrender or cancellation penalties, timeliness of payment, nor the likelihood of the use of a defense such as fraud to deny claims. For organizations with cross-border or multinational operations, including those conducted by subsidiaries or branch offices, the ratings do not take into account potential that may exist for foreign exchange restrictions to prevent financial obligations from being met.

Insurer Financial Strength Ratings are based on information furnished by rated organizations or obtained by Standard & Poor's from other sources it considers reliable. Standard & Poor's does not perform an audit in connection with any rating and may on occasion rely on unaudited financial information. Ratings may be changed, suspended, or withdrawn as a result of changes in, or unavailability of such information or based on other circumstances.

Insurer Financial Strength Ratings do not refer to an organization's ability to meet nonpolicy (i.e. debt) obligations. Assignment of ratings to debt issued by insurers or to debt issues that are fully or partially supported by insurance policies, contracts, or guarantees is a separate process from the determination of Insurer Financial Strength Ratings, and follows procedures consistent with issue credit rating definitions and practices. Insurer Financial Strength Ratings are not a recommendation to purchase or discontinue any policy or contract issued by an insurer or to buy, hold, or sell any security issued by an insurer. A rating is not a guaranty of an insurer's financial strength or security.

Insurer Financial Strength Ratings

An insurer rated 'BBB' or higher is regarded as having financial security characteristics that outweigh any vulnerabilities, and is highly likely to have the ability to meet financial commitments.

AAA

An insurer rated 'AAA' has EXTREMELY STRONG financial security characteristics. 'AAA' is the highest Insurer Financial Strength Rating assigned by Standard & Poor's.

AA

An insurer rated 'AA' has VERY STRONG financial security characteristics, differing only slightly from those rated higher.

A

An insurer rated 'A' has STRONG financial security characteristics, but is somewhat more likely to be affected by adverse business conditions than are insurers with higher ratings.

BBB

An insurer rated 'BBB' has GOOD financial security characteristics, but is more likely to be affected by adverse business conditions than are higher rated insurers.

An insurer rated 'BB' or lower is regarded as having vulnerable characteristics that may outweigh its strengths. 'BB' indicates the least degree of vulnerability within the range; 'CC' the highest.

BB

An insurer rated 'BB' has MARGINAL financial security characteristics. Positive attributes exist, but adverse business conditions could lead to insufficient ability to meet financial commitments.

B

An insurer rated 'B' has WEAK financial security characteristics. Adverse business conditions will likely impair its ability to meet financial commitments.

CCC

An insurer rated 'CCC' has VERY WEAK financial security characteristics, and is dependent on favorable business conditions to meet financial commitments.

CC

An insurer rated 'CC' has EXTREMELY WEAK financial security characteristics and is likely not to meet some of its financial commitments.

R

An insurer rated 'R' has experienced a REGULATORY ACTION regarding solvency. The rating does not apply to insurers subject only to nonfinancial actions such as market conduct violations.

NR

An insurer designated 'NR' is NOT RATED, which implies no opinion about the insurer's financial security.

Plus (+) or minus (-) signs following ratings from 'AA' to 'CCC' show relative standing within the major rating categories.

CreditWatch highlights the potential direction of a rating, focusing on identifiable events and short-term trends that cause ratings to be placed under special surveillance by Standard & Poor's. The events may include mergers, recapitalizations, voter referenda, regulatory actions, or anticipated operating developments. Ratings appear on CreditWatch when such an event or a deviation from an expected trend occurs and additional information is needed to evaluate the rating. A listing, however, does not mean a rating change is inevitable, and whenever possible, a range of alternative ratings will be shown. CreditWatch is not intended to include all ratings under review, and rating changes may occur without the ratings having first appeared on CreditWatch. The "positive" designation means that a rating may be raised; "negative" means that a rating may be lowered; "developing" means that a rating may be raised, lowered or affirmed.

'pi' Ratings, denoted with a 'pi' subscript, are Insurer Financial Strength Ratings based on an analysis of published financial information and additional information in the public domain. They do not reflect in-depth meetings with an insurer's management nor do they incorporate material non-public information, and are therefore based on less comprehensive information than ratings without a 'pi' subscript. 'pi' ratings are reviewed annually based on a new year's financial statements, but may be reviewed on an interim basis if a major event that may affect an insurer's financial security occurs. 'pi' ratings are not modified with '+' or '-' designations, nor are they subject to potential CreditWatch listings.

National Scale Ratings, denoted with a prefix such as 'mx' (Mexico) or 'ra' (Argentina), assess an insurer's financial security relative to other insurers in its home market. For more information, refer to the separate definitions for national scale ratings.

Quantitative Ratings, denoted with a 'q' subscript, were discontinued in 1997. The ratings were based solely on quantitative analysis of publicly available financial data.

Supreme Court...

continued from page 10

Training/Experience: Cuyahoga County 1970-1988; corporate attorney; JD, Cleveland-Marshall Law School 1963.

Endorsements/Key Contributors: Trial lawyers; OCSEA/AFSCME Local #11; Ohio Education Association; UAW Ohio State PAC.

Judge Stephen W. Powell (R)

Viewpoint: Believes that the role of the court is to decide cases based upon law as it is written and not create mandates to set political agendas for the justices.

Training/Experience: Judge, 12th District Ohio Court of Appeals 1995-present; court referee or county judge since 1984; JD, University of Dayton School of Law, 1981.

Endorsements/Key Contributors: Small business; health-care groups.

Supreme Court Seat #2 Race
Paul Pfeiffer vs. Ron Suster

Justice Paul Pfeiffer (R)

Viewpoint: Cited in a *Cleveland Plain Dealer* article as changing "more law as a member of the Supreme Court than he did as a state senator."

Training/Experience: Justice, Ohio

Supreme Court 1992-present; general legal practice 1973-1992; public sector attorney for 16 years; Ohio Senate, four terms; JD, The Ohio State University 1966.

Endorsements/Key Contributors: Trial lawyers; AFL-CIO, Ohio State UAW PAC; school unions.

Candidate Ron Suster (D)

Viewpoint: The judiciary must make decisions that are founded upon principles of objectivity and constitutionality, including that writing laws is the prerogative of the Legislature, not the judiciary.

Training/Experience: Judge, Cuyahoga County Court of Common Pleas; Ohio House of Representatives 1981-1995; general law practice 1970 - 1995; Assistant Ohio Attorney General 1971-1980; JD, Case Western Reserve University Law School, 1967.

Endorsements/Key Contributors: Ohio Fraternal Order of Police; Ohio Society of Certified Public Accountants; National Federation of Independent Business; Cleveland Building and Construction Trades Council; Ohio Association of Consulting Engineers; OSMA.

Governor's race...

continued from page 10

plans to cover government and school employees; advocates more freedom in the doctor-patient relationship including the right to choose a doctor or specialist, licensed practitioners overseeing all medical decisions by managed-care plans and availability of suits brought against managed-care plans.



Lee Fisher (D)

Training/Experience: Ohio House of Representatives; Ohio Senate; former Ohio Attorney General; JD, Case Western Reserve Law School 1976.

Endorsements/Key Contributors: Ohio AFL-CIO; Ohio Education Association; C.O.P.E.; Ohio Academy of Trial Lawyers; Ohio State UAW CAP Council; United Steel Workers of America. ■

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The **WINNER** will be notified **Dec. 7.**

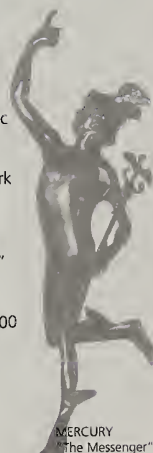
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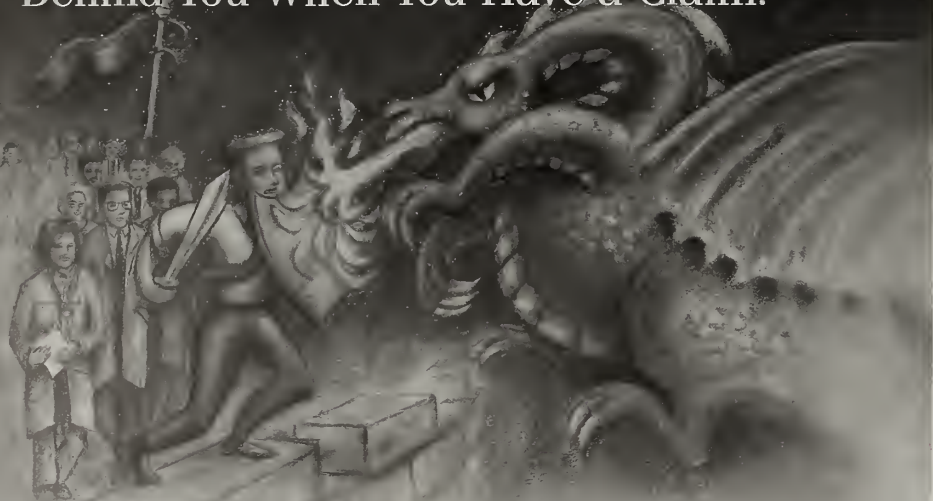
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OSMA News



This discussion can't wait

When was the last time you talked to your patients about domestic violence?

If you answered "two years ago" — when the OSMA launched its family violence campaign, encompassing child, domestic and elder abuse — then it's time to renew or make the commitment to ask your patients the hard questions that surround this troublesome social issue.

Domestic violence has not disappeared from the Ohio landscape just because we have stopped talking about it. One of my initiatives this year as president is to remind physicians to ask every patient who steps into his or her office not only about domestic violence but family violence as well. As an obstetrician-gynecologist, I focus primarily on domestic violence, but every patient, female and male, may be party or witness to an act of abuse at home. Our purpose is to raise the issue and shine light upon it so that, if a cycle of violence exists, it can be broken and healing can begin.

In 1996, the OSMA's Family Violence



Lance Talmage, MD

President's Perspectives

lence campaign acquainted physicians with the clinical and legal aspects of domestic, child and elder abuse, as well as ways we can help those discovered to be victims. The material on domestic violence is still pertinent today, and if you haven't had the opportunity, yet, to review this information, you should do so now. Domestic violence kits are still available, and CME credit can be earned on the material through the end of the year. (Next year, these kits will be updated and revised.)

Since then, the state has made immense strides in addressing the issue of domestic violence. Many of these initiatives began at the local level. For example, Toledo developed cards that could be placed in physicians' office restrooms, identifying shelters and other agencies that can help victims of domestic violence. These cards are now appearing in locations across the state. And, of course, the OSMA Alliance has been instrumental in keeping

the spotlight on the subject. At the Alliance's Fall Focus last year, domestic violence was the topic of the keynote address, and numerous county alliances have joined the effort to raise awareness about all types of violence and to help its victims.

What we do, as physicians, can improve health and quality of life for generations of patients. We must ask our patients if there is violence in their homes. Domestic violence is sufficiently prevalent that we can justify routine screening of all of our female patients. Ask women direct and specific questions about abuse. Include these questions as part of their social history, past medical history or history of present illness. Talk to them in a nonjudgmental way. *Trustalk*, the OSMA material on domestic violence, suggests you open with a statement like: "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely."

No matter what manner you choose to open discussions, the point is to open them. Don't let another two years go by before you raise the subject of domestic abuse with your patients. Don't even let another day go by. The subject is that important. ■

OSMA Web site...

Shopping at the OSMA store

The "OSMA Store," listed under "Membership Information" on the navigation buttons, allows you to purchase OSMA products online using a credit card. The credit card information is protected.

Members as well as nonmembers are invited to shop at the store. In most cases the information is free to members while nonmembers pay a fee.

Like browsing in your favorite bookstore, drop whatever you'd like to purchase into your "shopping cart." A tally is kept, so that when you finish shopping, you'll know exactly how much you've spent. Prior to paying the bill, you'll have a second chance to review your shopping cart and eliminate any items at that time.

The store offers the following OSMA-produced pamphlets and manuals:

- **Are You Covered?** This brochure helps your patients learn more about their health-care insurance, including a "how to" guide on asking the right questions.
- **Billing for Covered & Non-covered Services (Same Day)** Information concerning when and when not to bill the Preventive Medicine Codes (noncovered) with the E/M (covered) services.
- **Consulting Services Directory** A list of consultants specializing in managed care and containing information on managed-care products and services from the OSMA and the AMA.
- **Domestic Violence Kits** This handbook includes clinical guidelines, legal considerations and a list of county agencies to which

continued on page 15

Practice management seminars offered

November — The \$100,000 Office Manager

You'll review the basics of managing the medical practice, ensuring revenue enhancement, and reducing overhead and unnecessary spending.

Nov. 3 Sheraton City Centre, Cleveland

Nov. 4 OSMA Headquarters, Hilliard

Nov. 5 Dayton Convention Center

December — *Managing practice expenses and determining cost of*

services

This full-day workshop addresses the importance of prudent overhead management and reducing expenses.

Dec. 8 Sheraton Suites, Cuyahoga Falls

Dec. 9 OSMA Headquarters, Hilliard
Dec. 10 Holiday Inn Eastgate, Cincinnati

January — Personnel management

This workshop helps managers and physicians resolve many of the prob-

lems of the day-to-day demands of overseeing the practice, and to provide more time for attending to those responsibilities.

Jan. 26 Sheraton Suites, Cuyahoga Falls

Jan. 27 OSMA Headquarters, Hilliard

Jan. 28 Holiday Inn Eastgate, Cincinnati

OSMA contact: Amy Johnston, (800) 766-6762, Ext. 6726, e-mail: mgmt@osma.org ■

AMA continues to work with HCFA on E&M documentation guidelines

By Andrew Thomas, MD

Over the last two months, AMA leadership has met with HCFA staff in an effort to agree on documentation guidelines which meet AMA policy in opposition to "counting" of elements as part of the guidelines. However, it is now clear from these meetings that HCFA will not concede to completely eliminate "counting" from the final version.



Andrew Thomas, MD

In lieu of allowing HCFA to develop more onerous guidelines in a vacuum and in order to ensure that physicians are appropriately represented in the development process, the AMA Board of Trustees has asked the CPT Editorial Panel to resume its work with HCFA. They have clear direction from the board to minimize the role of "counting" in the final product. The Editorial Panel will also be distributing copies of an updated proposal to state and specialty societies for their comment this fall. These responses will have a large impact on the Editorial Panel's proposals to HCFA. Final implementation of any new documentation guidelines is not expected until late 1999. Currently, due to an indefi-

nite extension won by organized medicine, physicians may choose to follow either the 1995 or 1997 guidelines. For regular updates, visit the special E&M section of the AMA Web site.

Private sector advocacy

At its August meeting, the AMA Board of Trustees approved the Private Sector Advocacy Project's implementation plan and the additional expenditure of \$500,000 for the remainder of the year. The project's concept was approved by the AMA House of Delegates in June. It is designed to expose and combat abuses by managed care on the local, state or national level. AMA sponsored "swat teams" composed of physician leaders and staff experts who can be called into an area by local or state leaders to help provide a Federation response to unethical and unfair practices against patients and physicians. These responses may vary from media exposure to attempts at mediation to coordination of legal action.

In addition, at the direction of the AMA House, we are actively investigating the formation of an AMA-affiliated national collective bargaining unit for employed physicians, and are working to secure antitrust relief for nonemployed physicians. HR 4277, the Quality Health-Care Coalition Act of 1998, sponsored by Rep. Tom Campbell (R-Calif.), would allow any

physician groups to join together in negotiations with payors with the rights and protections afforded to traditional collective bargaining units by the National Labor Relations Act. The AMA testified in support of the bill in the House Judiciary Committee on July 29. For more information, please visit the AMA Web site.

Membership

The AMA will pilot a new membership package in four states (not Ohio) for 1999. It will allow physicians to join the AMA for substantially lower dues (approximately \$220) for basic benefits package of advocacy, "member-only" Web site access, and a news-letter-type publication. Additional benefits like JAMA, AMNews, CPT consultations, etc. could then be purchased "a la carte." The traditional \$420 membership package will remain available.

AMAP

The American Medical Accreditation Program (AMAP) has made its first round of accreditation decisions for more than 2,000 physicians in New Jersey this summer. AMAP is currently accepting applications in four states and the District of Columbia with contracts or letters of intent signed by 13 other state medical societies. The program is designed to allow physicians to be accredited by AMAP with that decision then being accepted by multiple

managed-care companies, hospitals and other entities. This will greatly reduce the paperwork and time hassles related to multiple accreditation forms and office visits to physician practices. Accreditation is not a replacement for board certification, but rather uses board certification as an important determinant in granting accreditation. For more information, visit the AMA Web site, or call (888) 881-AMAP. ■

Take Action

If you have any questions or comments regarding any AMA or Federation issue, contact Dr. Thomas by e-mail at thomas.302@osu.edu or of (614) 488-6866. You may also contact the AMA toll-free at (800) AMA-3211 or visit the AMA's Web site.

Andy Thomas, MD, Columbus, is a Resident Trustee member on the AMA's Board of Trustees.

Web resource

- AMA's Web site: www.ama-assn.org
- E&M section: www.ama-assn.org/emupdate
- Advocacy section: www.ama-assn.org/advocacy.htm
- AMAP section: www.ama-assn.org/amap

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OSMA store...

continued from page 13

physicians are either required to report signs of abuse or that provide assistance to patients. Please note that the CME credits for this book are due to expire at the end of the year. If you need CME credits by December, and have not yet used this source, now would be an excellent time to take advantage of the kit. Updated kits, again offering CME credits, will be issued next year.

- **ICD-9-CM Official Coding Guidelines** This brochure outlines the rules for diagnosis coding and reporting.

- **Living Will Kit** Individuals can obtain a living will and durable power of attorney kit for \$2 from the OSMA. Also included in the kits are organ donor cards, instructions and commonly asked questions and answers about the law itself. Members get a discount on additional kits.

- **Navigating Change** For half-price you can purchase the *Navigating Change: Options in a Managed-Care Environment*. An eight-book series offering insightful and usable answers to questions about managed-care methods that confront practicing physicians every day.

- **OSMA Resolution Guidelines** Guidelines for submitting resolutions to the OSMA House of Delegates meeting.

- **Pending Legislation** This fact sheet provides the latest information on pending legislation monitored by the OSMA.

- **Physicians Guide to Ohio Law** For the latest information about laws, ethical opinions and other guidelines that affect various aspects of your medical practice.

Take Action

If you have problems, comments or suggestions for the OSMA Web site e-mail: Koren Kirk at ohiomed@osmo.org or call at (800) 766-6762, Ext. 6754.

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OSMA Profile

A demographic look at your association.

Female physicians

In 1867, Ohio's Western Homeopathic College denied entrance to women who wanted to become physicians. Since then, of course, women have become a significant force, not only in Ohio health care, but also in the OSMA. Nermin D. Lavapies, MD, blazed the trail for women in organized medicine by becoming the association's first female Councilor. And in 1994, the OSMA elected its first woman president, Claire V. Wolfe, MD.

Today, the OSMA counts 900 women among its members. Most of these women are between the ages of 30-39 (332) and 40-49 years (326), followed by women who are 50-59 years (139). There are 42 women between the ages of 60-69 who are in active practice; 21 between the ages of 70 and 79; and one 85-year-old is the oldest woman in active practice. The youngest female OSMA members are 28



Source: OSMA Electronic Data Processing Department

and 29 years old.

Here are the top 10 specialties of OSMA's women physicians:

- | | |
|----------------------------|--------------------------|
| 1. Family practice (149) | 6. Ophthalmology (31) |
| 2. Internal Medicine (110) | 7. Dermatology (28) |
| 3. Pediatrics (107) | 8. Psychiatry (27) |
| 4. Ob-Gyn (97) | 9. Pathology (27) |
| 5. Anesthesiology (33) | 10. General Surgery (25) |

At your service... OSMA offers group plans

Instead of wading through insurance brochures, you can look to the OSMA to find the insurance coverage you need. The OSMA Insurance Agency offers group health plan coverage for OSMA members, their staff and families through Medical Mutual of Ohio (MMO).

John Mayer, OSMA Insurance Agency, says the MMO plans offer members either a traditional insurance policy or a managed-care plan. With the traditional coverage, the member pays the deductible each year. Medical services over that are reimbursed at 80% of the usual, customary and reasonable rate (UCR) up to a specific amount.

You may also choose:

- **SuperMed Plus** – a Preferred Provider Organization plan. Receive care from physicians and facilities within Medical Mutual's network of hospitals and health-care facilities or go outside the network to a health-care professional of your choice.

- **SuperMed Select** – a Point-of-Service plan. Select a primary care physician from the POS provider network who serves as gatekeeper, providing or overseeing your medical care. If specialty care is needed, referrals will be made to a specialist in the POS provider network.

- **SuperMed Classic** – Choose your physician and still receive some of the "cost advantages" of a managed-care hospital network.

Mayer says each plan has its advantages and disadvantages. No matter what your preference, you're sure to find it through the OSMA. – *Kaci Brown*

Take Action

You must be an OSMA member, or have at least one OSMA member in your group; work at least 20 hours per week and be within Medical Mutual's service area to enroll. For more information on OSMA's group health or other insurance plans, contact the OSMA Insurance Agency, (800) 860-4525.

'Chicken soup for leaders' may become annual event

As medicine struggles with the challenges of today's threats to undermine the physician-patient relationship, to divide and polarize the various constituencies of the profession and to denigrate the reputation of a noble profession, so, too, does the Alliance. Its network of physician spouses, struggle with the fallout of all of this. We serve medicine in our communities with our talents, attempting to meet whatever needs our counties may have. We are as dedicated as our physicians to fulfill our share of responsibilities.



Nancy Goorey, DDS

Alliance Report

We are also dedicated to continuing our efforts at serving our communities in the name of medicine, and this means we need new leaders and we need to train them. It is our responsibility to nurture our emerging leaders and help prepare them for the future. They are the key to keeping our part of this profession intact and functional.

On July 8, the OSMA Alliance presented a workshop, "Chicken Soup for Leaders." The invitation to attend included county officers and committee chairs. The agenda began with an in-

formal "Getting to Know You" activity, reflecting the theme that will run through this year. Joy Myers, OSMA parliamentarian, presented an interactive program including presiding, administrative, and relationships, internal and external. At noon, the participants met in groups for Lunch and Learn sessions. These included: health promotion, chaired by Eleanor (Bunny) Johnson; legislation, chaired by Amy Han; membership, chaired by Dolly Handel. The district directors met with President-Elect Jan Kirlin and Vice President Shirley Powers.

The afternoon was billed as "Solving Today's Problems (This is not your mother's auxiliary)" and ended with Meeting Management, with participants acting as presiding officers.

Forty-one Alliance members at-

tended from 15 counties. They were young, they were enthusiastic, and they are committed to medicine and to their communities. Chicken Soup was so well received that, at the suggestion of participants, it may become an annual event.

The Sept. 18 board meeting was held at Moundbuilders Country Club in Newark, to coincide with the OSMA Council meeting. OSMA officers and councilors' spouses were invited to join the board for a luncheon.

We are off to a great start, and look forward to a very productive year. ■

Nancy Goorey, DDS, is president of the OSMA Alliance.

OSMA happenings...

- Medical students expand their page on Web...Check out the expanding Medical Student page on the OSMA's Web site, www.osma.org (you'll find it under the membership button). Abhi Mehrotra and Brad Harrold, both members of the Medical Student Section (MSS) are working with OSMA staff to link the OSMA site to the home pages of each of Ohio's medical schools, where those are available. If the school has no Web site (all schools are expected to be online by the end of the year), the e-mail address of that school's representative is provided. Also new: a link to the AMA's medical student page; a list of current MSS officers; and an application form for students to join online, plus a list of upcoming MSS meetings.

- Dr. Polsley runs for AMA post... J. Steven Polsley, MD, Urbana, is running for a position on the American Medical Association's Medical Services Council. Elections will be held in December at the AMA's Interim Meeting in Hawaii. Dr. Polsley is a former third district Councilor and serves as a member of the Ohio delegation to the AMA.

- Educational brochure sent to nonmember women physicians... Lucy Mullis Kitner, OSMA membership development manager, has launched her targeted recruitment efforts with an educational brochure for nonmember women physicians. "We focused on their time, or lack of it, and the services the OSMA offers to help them save time," she says. Kitner drew on AMA and OSMA research regarding women physicians as well as from her own one-to-one discussions with members. Although the brochure doesn't dwell specifically on gender issues, it touches on OSMA involvement in family violence issues, sexual harassment, and gender disparity in research. For a copy, contact the reader response line, (800) 766-6762, Ext. 6580 and ask for Item # 31-98.

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Practice Tips



Coding corner

How to use modifier 25

Modifier 25 may be the most confusing modifier in CPT. Attaching it to an E/M service results in almost certain denial – 99% of the time. Now it's on the Office of the Inspector General's "hot target" list.

You know how you used to use it – modifier 25. A patient came to your office for a minor procedure and, while there, for whatever reason, an E/M service became medically necessary.

This is still a justifiable reason to bill these services together, says OSMAs certified coder Jillian Phillips, MA, CCS-P, CPC. "Although third parties tend to ignore the different diagnoses and deny the E/M service anyway," she says.

It's imperative to understand, however, that one of the Office of the Inspector General's "hot target" indicators is when a high level of E/M service is billed with modifier 25 along with another service or procedure. While it's possible to justify a higher level of service (performed with a separate service with a different or same diagnosis), it won't be easy, says Phillips. It's generally assumed that if the patient is there for the high-level service, the other service would be best performed at another time.

"And while the modifier is used whether or not the patient is new or established, it's easier to justify when the patient is new," says Phillips. "It's just more difficult to justify any service over and above the usual pre-and post-op for an established patient. If the established patient had a medical problem that could complicate even the most minor procedure, it stands a better chance of being reimbursed,"

she says. "In most of these cases, however, you should expect a claim review."

Here are some questions to ask when you think you might need to use modifier 25:

1. Why did the patient come to see the physician? Are there signs, symptoms, and/or conditions that the physician must address before deciding to perform a particular procedure or service?

If the answer is yes, then an E/M service may be billed with the modifier 25.

2. Was the physician's evaluation and management of the day's problem "significant, separate, identifiable, above and beyond services normally included in the procedure and/or service"?

If the answer is yes, then an E/M service may be billed with the modifier 25. But be careful. If the answer is no, then it's best not to bill it because the patient is established and the problem is recurrent.

3. Was the patient in the office for a scheduled procedure?

If the answer is yes, then an E/M service is not medically necessary, and only the scheduled service or procedure may be billed, as the history, exam and/or decision-making was already performed at another time.

4. What happens when the patient presents with multiple diagnoses during an E/M service, and how is that billed? Is the 25 modifier still necessary?

The specific diagnosis that is, or would be, the reason for the procedures or other service is the one that is assigned to that service or procedure. The other diagnoses are coded with the E/M service with the modifier 25.

5. What is the proper way to code when a patient presents with signs and/or symptoms (i.e. the reason for the visit) and then it is determined that another procedure or service should be performed that same day?

If a final diagnosis(es) is determined after the physician performs the history, exam and decision-making in relation to the signs and/or symptoms, then the E/M service should be coded with the signs and/or symptoms and modifier 25, and the other service or procedure is coded with the final determined diagnosis(es). ■

Take Action

This information and more is offered this month through the OSMAs's new seminar, "Documenting, Coding and Auditing the Evaluation & Management Services." If you have a question about this material, contact Jillian Phillips, OSMAs Department of Ombudsman Services, (800) 766-6762, Ext. 6758.

How to prepare for E&M audit

Throughout October, the OSMAs is offering a new seminar, "Documenting, Coding and Auditing the Evaluation & Management Services," presented by certified coder Jillian Phillips, MA, CCS-P, CPC.

The seminars will provide a comprehensive look at the E&M codes and their modifiers, with emphasis on proper code selection based on the old, new and (projected) revised documentation guidelines.

Cost to members and/or their staff is \$100. Nonmember cost is \$185.

Mansfield/Thurs., Oct. 1 – Comfort Inn, 500 North Trimble Road

Columbus/Fri., Oct. 2 – OSMAs Headquarters, 3401 Mill Run Drive, Hilliard

Chillicothe/Thurs., Oct. 8 – Christopher Conference Center, US Rt 23 and 35, 30 North Plaza Blvd.

Cambridge/Fri., Oct. 9 – Holiday Inn, 2248 Southgate Parkway

Lima/Tues., Oct. 13 – Holiday Inn, 1920 Roschman Ave.

Toledo/Wed., Oct. 14 – Holiday Inn French Quarter, 10630 Fremont Pike, Perrysburg

Dayton/Tues., Oct. 20 – Dayton Marriott, 1414 Patterson Blvd.

Cincinnati/Wed., Oct. 21 – Radisson Hotel Cincinnati, 11320 Chester Road

Cleveland/Tues., Oct. 27 – Sheraton City Center, 777 St. Clair Ave.

Boardman/Wed., Oct. 28 – Holiday Inn Boardman, 7410 South Ave.

Take Action

To register, contact Cathy Sannhalter, OSMAs Department of Ombudsman Services, (800) 766-6762, Ext. 6759.

10 ways to keep accurate records

Each physician has his or her own way of keeping medical records. The following suggestions, from the ODMA fact sheet "Medical Record Keeping," is not meant to be used as a standard or as legal advice. But if you wish to maintain accurate medical records, you may want to follow these 10 steps:

1. Record the patient's identification on each page of the chart. Use a separate file for each family member.
2. Record the complete date. That's day, month, and year – put it on each entry.
3. Sign each entry. Don't forget to write down your title or position.
4. Use permanent (preferably black) ink.
5. Write legibly. Print if necessary, and use only standard abbreviations. If your notes are entered into a patient record by someone other than yourself (or electronically), be sure to review and initial them.
6. Record all of the following information immediately:
 - mode of contact (phone, office visits, etc.)
 - reason for contact
 - treatment, information, or advice given
 - outcome of contact
 - plan for future or follow-up care.
7. Fill in all blanks, recording positive and negative information.
8. Correct any error or mistake by drawing a single line through the incorrect portion, writing "error" above the lined-out item, and initialing and dating the error.
9. Prominently display all medications and patient allergies.
10. Document all patient instructions and educational materials given.

Select the words and information you include within the record carefully. Also, remember that a medical record should only contain information that is useful for the ongoing care of the patient. ■

Take Action

There are some charting pitfalls you should avoid as well. For a list of 10 pitfalls to avoid, contact the *Ohio Medicine* reader response line and ask for Item #30-98, a copy of the ODMA fact sheet on medical record keeping. The pitfalls are listed on the back. You can also check out the fact sheet on ODMA's Web site, www.osma.org. See the "Hot News" section, and select the legal fact sheets option.

ODI puts two HMOs in supervision

The Ohio Department of Insurance placed Health Power Inc.'s HMO product under supervision in July after it failed to meet financial requirements. Health Power's policyholders are largely Ohio Medicaid recipients, enrolled in the Columbus, Dayton and Cincinnati areas. The company is authorized to conduct business in 19 Ohio counties. Also under rehabilitation orders is Personal Physician Care, Inc. The ODI placed this HMO under supervision in August after finding the company in "poor financial condition" (financial reports indicate it had a negative net worth of \$15.9 million). Without a potential buyer, the department was set to liquidate the company at press time. PPC serves about 34,000 Medicaid clients, primarily in northeast Ohio.

John Alden surrenders Ohio HMO license. John Alden Health Systems has surrendered its Ohio HMO license. According to news reports, the insurer changed its expansion plans when it was acquired by Fortis. The company never developed an HMO in Ohio and now is involved in managed care only in Florida.

Emerald Health Care makes the Medicaid cut. In the April issue of *Ohio Medicine*, an article projected that Emerald Health Care might not be among the surviving HMOs in the state's Medicaid program. The Department of Human Services had decided to cut those HMOs that had below a 15% enrollment (10% in Cuyahoga). Emerald has notified *Ohio Medicine* that it has met the Medicaid managed-care plan's minimum enrollment requirements, including those in Cuyahoga and Summit counties.

Total Health Care buys DayMed. Dayton-based DayMed, an HMO serving more than 15,400 Medicaid enrollees in five southwest Ohio counties, has been purchased by Total Health Care, possibly saving it from rehabilitation or insolvency. Total Health Care is a Medicaid HMO serving about 28,000 enrollees in Cuyahoga, Franklin, Mahoning and Summit counties.

Managed-care Roundup

Analysis available for Anthem amendments. The ODMA's Division of Legal Affairs has prepared an analysis of the contract amendment Anthem added to all existing provider agreements Sept. 1. Anthem says amendments are part of an effort to standardize provider contracting. (Reimbursement levels are not affected in the amendments.) Letters describing the changes were mailed to Advance Plan and managed-care providers in July. If you would like a copy of the ODMA analysis, contact the *Ohio Medicine* reader response line at (800) 766-6762, Ext. 6580 and ask for Item #32-98.

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My favorite Web site...

Carol Sholtis, MD

www.foodtv.com

"When we were in Florida, we watched the channel and loved it. I found the same information on the Web site as on the TV shows – including all the recipes. They also have all kinds of things you can buy."



Carol Sholtis, MD

"It's nice because if you don't have time to watch the shows you can go back and get the recipes you wanted from the site," she says.

What to look for: E-mail an expert chef for advice on your cooking dilemmas or view a chef's answers to commonly-asked questions. Search through the site's state-by-state listings to find places to eat while on vacation – or for a new hometown restaurant.

Need help deciding what to cook for dinner or what wine to choose when dining out? Browse through the site's program listings or visit its "From the Vine" column. In the program listings you'll find recipes featured during last week's FoodTV programs and see topics for upcoming shows.

www.asco.org

"I use the ASCO's (American Society of Clinical Oncology) site to find updates on medicine and oncology.

"The site has a good program where doctors can send patients to get up-to-date information about health care. There's also a place where doctors can (find ways to) obtain CME credit."

What to look for: The ASCO site's main page includes general information on the association and links to specialized cancer information. The home page has a link for "People Living with Cancer" and one for "Oncology Professionals."

In the "People Living with Cancer"

continued on page 21

Favorite...

continued from page 20

section, cancer patients and/or family members can read information approved by the ASCO editorial board. Patients can also link to other Web sites that are useful sources of information and support.

For oncology professionals, the site features a "News Releases" section linking to news articles from the *Journal of Clinical Oncology*. Doctors can also browse through a calendar of upcoming oncology-related meetings and continuing education opportunities. An OnLine Center offers software and book reviews, and links to other cancer-related organizations. — Kaci Brown

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A Publication of the Ohio State Medical Association

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JOHN W. FRANKLIN, JR, MD, Chillicothe, University of Cincinnati College of Medicine, Cincinnati, 1946; age 75; died July 11, 1998.

ROBERT C. HAWKINS, MD, Toledo, University of Nebraska College of Medicine, Omaha Neb., 1939; age 83; died July 15, 1998.

JOHN K. KRIEG, MD, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1967; age 58; died Aug. 15, 1998.

DONALD C. MARTIN, JR, MD, FACS, Toledo, University of Pennsylvania School of Medicine, Philadelphia, 1962; age 61; died July 21, 1998.

HAL B. MCLEAN, MD, FACS, Arizona, University of Kansas School of Medicine Lawrence, Kansas City, Kan., 1942; age 84; died July 25, 1998.

MATTHEW PENTZ, MD, Bellville, Universitaet Graz, Medizinische Fakultät, Graz, Austria, 1955; age 75; died July 23, 1998.

SHELDON PELCHOVITZ, MD, Cincinnati, University of Toronto Faculty of Medicine, Toronto, 1974; age

Obituaries

48; died July 20, 1998.

MAX H. ROSENBLUM, MD, Steubenville, Ohio State University College of Medicine, Columbus, 1927, age 80, died July 29, 1998.

REXFORD P. RUTTER, MD, Toledo, University of Michigan Medical School, Mich., 1952; age 78; died July 17, 1998.

CARL F. SCHILLING, MD, FACS, Cincinnati, University of Cincinnati College of Medicine, Cincinnati, 1941; age 85; died Aug. 10, 1998.

RICKARD, TOOMEY, MD, Cleveland, Case Western Reserve University School of Medicine, Cleveland, 1937; age 61; died Aug. 2, 1998.

PHILIP B. WASSERMAN, MD, Cincinnati, University of Rochester School of Medicine-Dentistry, Rochester, N.Y., 1934; age 90; died Aug. 9, 1998.

CAESAR S. BASSETTE, JR, MD, Cincinnati, has been honored with the Lifetime Achievement Award by the Cincinnati Obstetrics and Gynecology Society.

RAE HARTMAN, MD, Walnut Hills, received the Loretta Richard Distinguished Alumni Award. The award is named in honor of the first Alumni Association president.

STEPHEN T. KONDASH, MD, Cincinnati, has been elected president of the Cincinnati Society of Ophthalmology for 1998. Dr. Kondash practices out of Tri-State Eye Care's Western Hills and Harrison offices.

LAWRENCE KURTZMAN, MD, Cincinnati, plastic surgeon, led his third medical mission to Nicaragua, his 16th for Operation Smile.

MARK A. MALANGONI, MD, FACS, Cleveland, was elected president of the Ohio Chapter, American College of Surgeons at the chapter's 43rd meeting, in Columbus.

ALBERT S. MALCOLM, MD, Middletown, is the new president of the Butler County Medical Society.

O'DELL OWENS, MD, Cincinnati, former chair, board of trustees, University of Cincinnati, has joined the Franciscan Health System of the Ohio Valley, Inc. as senior vice president of women's health services.

GEORGE W. PAULSON, MD, Columbus, was presented the Madden Foundation Humanitarian Award for outstanding community service at the 1998 Parkinson's Disease Recognition Gala in Columbus.

Colleagues

ISRAEL PENN, MD, Cincinnati, a professor of surgery and director of surgical student education, received the Dolly Cohen Award for Excellence in Teaching from the University of Cincinnati.

MICHAEL R. PETERSEN, MD, Cincinnati, was elected to the board of trustees, Cincinnati Association for the Blind. Dr. Petersen is director of Vitreoretinal Services at the Cincinnati Eye Institute.

RONALD A. POHLMAYER, MD, Findlay, received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Blanchard Valley Regional Health Center.

DANIEL S. RENNER, MD, Mayfield Heights, chief of Thoracic Surgery at Meridia Hillcrest Hospital, just returned from Brazil and a medical mission trip with Operation Blessing. He worked in Recife doing general and thoracic surgery.

G. JAMES SAMMARCO, MD, Cincinnati, has been appointed the representative for the North American Continent in the International Federation of Foot and Ankle Societies.

KATHRYN ANN WEICHERT, MD, Cincinnati, an oncologist and therapeutic radiologist, was named guest of honor for the American Cancer Society's 14th Annual Black-tie Gala.

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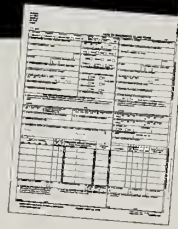
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November 1998

Ohio Medicine

4

Nurse prescribing will remain a hot legislative issue in 1999. OSMA members who responded to a survey on the issue will help Council decide how the association will proceed at the Statehouse next year.

11

The jury duty exemption should be returned, say those who responded to Ohio Medicine's fax-back response to Chief Justice Thomas Moyer's editorial on: Why doctors should s



14

A profile of group practices in Ohio – including group location, size, structure, benefits, and compensation, emerged from the OSMA's annual group practice survey. If you're in a group, see how yours stacks up against the others.

19

Is your office system ready for the year 2000? You've heard about the Y2K problem, now, Ohio experts tell you what you need to know to prepare your practice for the new millennium.

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Counting formulas will remain a part of new E&M guidelines

The AMA did not want quantitative formulas included in the new E&M guidelines, but HCFA says they will stay. However, the guidelines will undergo a testing process before they are implemented.

The Health Care Financing Administration (HCFA) may be reworking its documentation guidelines in Evaluation and Management (E&M) services, but don't expect the federal agency to drop "counting" formulas as a requirement — despite AMA and OSMA strong objections.

This summer, AMA delegates sent HCFA a loud and clear message: Eliminate the quantitative formulas from the guidelines and pilot test any guidelines so that physicians can have an opportunity to provide input.

HCFA issued its response to the AMA in late September. The agency says it will develop a new set of E&M guidelines to replace its 1995 and 1997 versions, but the new guidelines will require some counting of the number of actions a physician takes during a physical exam. According to HCFA, some counting is necessary to determine the correct E&M code level to be billed.

The seminars on E&M documentation guidelines, presented by OSMA certified coder Jillian Phillips, included how-to information on counting, says Phillips, so, already, seminar participants may be ahead in understanding and completing the new forms.

HCFA says it will use the guidelines developed by the AMA and other physician groups and the CPT-4 Editorial Panel as a starting point for its new

guidelines. And the agency has agreed to a testing phase, as per the AMA's request. Once developed and tested, HCFA will educate physicians and Medicare carriers on use of the new forms.

The AMA Board of Trustees has asked the CPT Editorial Panel to resume the process of providing technical advice to HCFA — to ensure the new guidelines minimize physicians' burdens, diminish counting formulas as much as possible, and stay consistent with CPT definitions.

Until the new guidelines are created, physicians should comply with the



The E&M documentation seminars held in October featured how-to information on counting. OSMA's certified coder, Jillion Phillips, right, answers questions from attendees.

1995 or 1997 documentation guidelines. HCFA's new guidelines are not expected to be implemented before late 1999. ■

Supreme Court hears tort-reform suit arguments

The Supreme Court heard oral arguments last month in a lawsuit, brought by trial lawyers and Ohio AFL-CIO, that declares Ohio's



Chief Justice
Thomas J. Mayer

year-old tort reform law unconstitutional. But don't expect a decision from the high court until late next month.

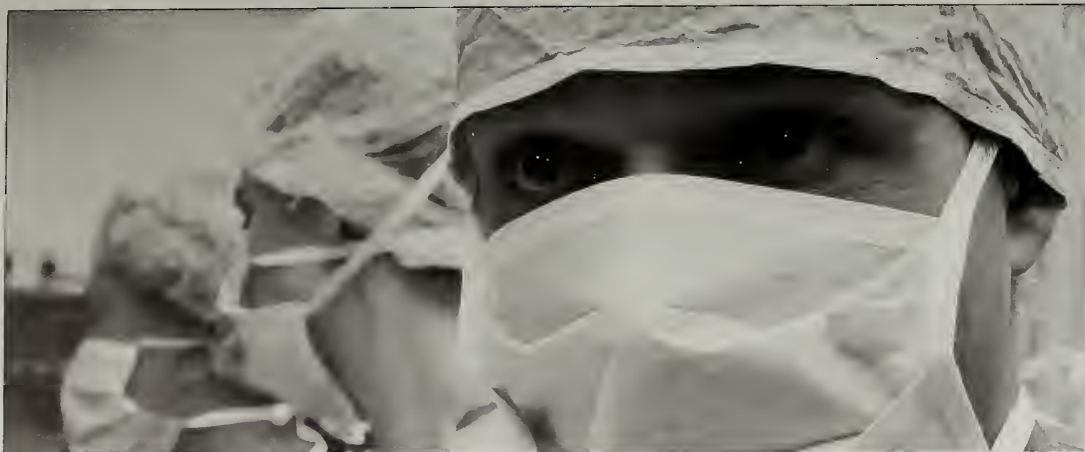
The tort-reform law (House Bill 350), which became effective in Janu-

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Court....

continued from page 1

ary 1997, makes significant changes in Ohio's civil justice system, including a cap on awards for noneconomic damages (i.e. pain and suffering awards.) The law is supported by the OSMA and other health and business groups through a coalition known as the Ohio Alliance for Civil Justice.

Rather than allow the law to be tested, first, in lower courts, the plaintiffs petitioned the Ohio Supreme Court directly, saying that the decision will impact so many cases that a verdict from the top court will expedite court dockets across the state. According to opponents, the tort-reform law violates a constitutional prohibition on passing bills that contain more than one topic. In addition, opponents also say that legislators overstepped their authority; that the right to trial by jury is restricted by the provision limiting damage awards; and the Ohio Constitution prohibits limits in wrongful death awards.

Proponents, however, say there is no evidence or other indication that any party, besides personal injury lawyers, has been harmed by the law.

According to an article in *The Columbus Dispatch*, Chief Justice Thomas J. Moyer questioned bypassing the lower courts, commenting that the case "cries out for evidence...There are a lot of issues on which I need some record, some evidence. I have trouble understanding why the common pleas courts don't have jurisdiction to hear this case." Justice Deborah L. Cook sided with Chief Justice Moyer, saying the court must presume a law is unconstitutional until it is proved otherwise. Moyer, Cook and Justice Evelyn L. Stratton voted against hearing the case but were outnumbered by Justices Paul E. Pfeifer, Francis E. Sweeney, Andrew Douglas and Alice Robie Resnick.

"This is another reason why doctors need to become more knowledgeable on the judicial candidates and their activities," OSMA Legislative Director Tim Maglione said earlier this year. Future OSMA wins at the Statehouse are likely to be challenged in court, so it's important for physicians to vote for those candidates who exercise judicial restraint. ■

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Bills, Laws & Rules

APN survey results

Respondents opposed to granting prescriptive authority to APNs

When the Ohio Legislature reconvenes in 1999, there will likely be a heated legislative debate on what was, in 1998, House Bill 667 — the issue of whether advanced practice nurses (APNs) will be allowed to prescribe medicines in Ohio. The bill's wording, formulated by the nurses' association, allows APNs to prescribe schedule II to V drugs within a collaborative arrangement with a physician. A previous law established the right for APNs to work in a collaborative relationship with physicians.

House reaffirms opposition

Historically, the OSMA has consistently opposed prescriptive rights for APNs to prescribe independently. In May, the House of Delegates reaffirmed its current policy against APN prescribing, Resolution 35-94, and further resolved in Amended Resolution 08-98 that: "The OSMA oppose legislation relating to advanced practice nurses that includes formation of an autonomous advanced practice nurses regulatory committee/board which would establish practice parameters, formulary and prescribing authority."

To help further define member opinion on this issue, the department of legislation recently surveyed a portion of the association's membership to ascertain not only opinions related to APN authority but also to assess the current level of APN activity in medical practice. The survey, just completed, sought to gauge the opinion of organized medicine and sample the issue's intensity.

More than 400 OSMA members responded to the questionnaire that appeared with the September issue of

Leadership Briefing. The results will help the OSMA Council decide how to handle the issue at the Statehouse in 1999. One option would be to launch a full-scale effort to stop the legislation. Another option would be to negotiate a position with the APNs that would build in an acceptable minimum level of training and a series of guidelines for professional supervision, regulatory oversight and doctor/APN ratios. Or, the OSMA could endorse the bill.

APN proposal weak

Results from the survey showed that 76% of the respondents were opposed to granting prescriptive authority to APNs. Of those who were supportive of APN prescribing, most believed the proposal as written did not offer adequate protection from patient care. The OSMA, along with other opponents of the measure, generally agree that allowing prescriptive authority to APNs blurs the lines between the practice of medicine and the practice of nursing. Physicians voice a concern that it takes significantly more training in the medical basic sciences to effectively perform the diagnosis that precedes a prescriptive decision. They would argue that allowing APNs to prescribe medications is analogous to allowing an architect to evaluate the structural integrity of a failing bridge: a structural engineer would be a more judicious choice because of the professional standards and licensing that person would already have.

Nurses launch campaign

Proponents of the issue, mostly nurses' associations, have mounted a grass-roots campaign, working closely with legislators to raise their awareness

and support for the issue. They assert that, especially in medically underserved urban and remote rural areas, APNs could fill a vital niche (although there is argument on whether or not APNs actually practice in these areas.) Nurses argue that 48 states allow some kind of prescriptive authority, ranging from closely supervised work with a physician to limitations on the categories of drug prescribed to real independence of action.

Pilot projects offer no proof

Currently, there are three pilot programs for APN prescriptive action under way in Ohio. The APNs point to these as proof that prescriptive authority works, yet the OSMA believes the projects have produced no real data by which to judge these collaborative arrangements.

The OSMA will continue to oppose this legislation, but you should know that this perennial battle is expected to be a high-profile issue in 1999. *Ohio Medicine* will keep you posted. — Yvonne Burry

Plans favor APNs prescribing

The Ohio Association of Health Plans surveyed its members to determine current use of APNs — 33% of plans indicated they would be more likely to incorporate APNs into their provider panels if they held prescriptive privileges in Ohio.

OAFP looks to temper but support APN prescribing

On the previous attempt to enact APN prescriptive authority, the Ohio Association of Family Physicians (OAFP) sided against the OSMA and came out in support of APN prescribing (under certain conditions.)



Dr. Welker

As Mary Jo Welker, MD, a past OAFP president, put it in an editorial that ran in the January 1996 issue of *Ohio Medicine*, "The alternatives may not be as acceptable as what we have presented before us (the legislation)." One significant concern, she wrote, is that the pilot projects will continue to expand, and "we will have a number of nonmastered-prepared advanced practice nurses prescribing in collaborative relationships (not under supervision) throughout the state of Ohio.

"Are there still some technical problems with the legislation that need to be worked out? Yes. Can the OSMA, with its influence in the Legislature, make some changes if the organization is willing to agree to prescription privileges under the above circumstances? Yes."

This time around, things don't appear very different.

Ann Spicer, OAFP executive vice president, said that the OAFP legislative committee was considering the issue and might draft some guidelines for prescriptive authority — for APNs or physician assistants (PAs).

Spicer said the OAFP is searching for wording so they could be supportive of APNs or others. The OAFP may try to develop a standard for mid-level practitioners, especially regarding the level of authority and supervision requirements. — Yvonne Burry

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Quick news

Antitrust complaint filed against Cincy physicians...United HealthCare, Inc. has filed an antitrust complaint against the Federation of Physicians and Dentists (FPD) and those Cincinnati physicians who have affiliated with the union. United HealthCare officials say that, in negotiating with physicians who were operating through an FPD messenger model, the officials heard "common responses and common objects" suggesting coaching had occurred.

Bill to prevent insurance collapse dies in committee...Don't look for a quick legislative solution to prevent future collapses of other malpractice carriers like PIE Mutual Insurance Company. The House Insurance Committee killed a measure (House Bill 1717) that, had it passed, would have required at least a third of the directors of each insurance company regulated by the state to be outside the corporate structure. The bill also would have authorized the director of the Ohio Department of Insurance to conduct an examination of any insurer that fails to file forms with the department in a timely manner. It is unclear whether this bill will resurface next session.

BWC managed-care challenge case is defeated...Northwestern Ohio Building and Construction Trade Council lost its suit charging that the Bureau of Workers' Compensation's Health Partnership Program improperly delegated decision-making authority to participating managed-care organizations, in violation of the Ohio constitution. Toledo attorney, Theodore Bowman, representing the Council, says an appeal is likely.

Bill would establish eye health fund...House Bill 756 creates a volunteer fund to provide the financial resources needed to train health and child-care workers to conduct proper vision screens, ensure youth sports teams have proper eye wear, implement education programs and create an amblyopia registry. The Ohio Department of Health would administer the fund and develop various sight education programs. Funds would be requested through a voluntary check-off system from motor vehicle registrations.

Supreme Court to hear patient info case...The Ohio Supreme Court will hear a case involving the dissemination of patient information. In *Biddle v. Warren General Hospital*, the hospital worked with a local law firm which contacted SSI-eligible patients and tried to get them to apply for and have their hospital bills paid for through Medicare.

Guidelines available regarding Pap smears, litigation...In Resolution 36-98, the OSMA House of Delegates stated that the association supports the Guidelines for Review of Pap Smears in the Context of Potential Litigation, passed by the Ohio Society of Pathologists on May 9, 1998. If you would like a copy of these guidelines, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #34-98.

• INTERNAL MEDICINE •

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Please forward curriculum vitae to: Frank M. Klaus, Mednet Physicians, Inc., 23001 Euclid Avenue, Cleveland, OH 44117-1600; phone 216-383-6385; fax 216-383-6741.

Patient bill of rights battle continues

It's been an interesting year for debate in the nation's Congress and in the Ohio Legislature. What we've witnessed on the national level has been one of those uniquely bipartisan rallies, where both parties support the same type of bill, but can't quite overcome their differences. Initially, President Clinton helped the Democrats develop a foothold with the "Patient Bill of Rights," which got the Republicans working on their own version of health-care reform. But neither group could muster the 60 votes needed to bring its bill onto the Senate floor. And what we're left with now – and we are left waiting because no significant vote can take place until the elections season passes – is no response to the growing public concern over managed care.

Accountability still an issue

A key issue in what has hampered federal lawmakers is the accountability piece that allows a patient who has been harmed by a negligent managed care to seek a judicial remedy and thus recover compensable damages. (See *Presidential Perspectives*, page 18, for more information on this subject.) Meanwhile, states like Ohio have found their own solution to the issue with their own enactments.

Ohio is one of the first states in the nation to pass such a bill that comprehensively tackles so many of the Patient Bill of Rights issues. OSMA worked with Kaiser Permanente to create Ohio's managed-care reform bill, the Physician-Health Plan Partnership Act (HB 361), which became law on Oct. 1.

What's interesting about Ohio's passage of the Physician-Health Plan Partnership Act is that many Ohio lawmakers and the OSMA are trying to send a message to Washington saying: "Look, we passed significant legislation in Ohio. Surely, Congress can follow our lead and get some similarly significant legislation passed!"

Along that same theme, it is no surprise that both this year's Ohio gubernatorial candidates essentially have the

same platform on health care. For once, party politics are taking a decidedly back-seat role to an important issue. In fact, both Bob Taft and Lee Fisher support the two very essential issues within the managed health-care arena:

- Point of service (POS) requirement for health plans so that patients can see a physician outside their health plan by paying an additional co-pay or deductible.

- HMO accountability where HMOs will be held to task when making negligent treatment decisions.

Ohio introduces Patient Bill of Rights

A Patient Bill of Rights for Ohioans, introduced toward the end of this legislative session, grew from Lee Fisher's campaign promises. It includes a provision that calls for managed-care accountability, and the OSMA is monitoring its progress – but it's unlikely to see any real action this year.

Any legislative action, in fact, is likely to wait until next year, when a new governor is in place and there are new legislators to consider these health care "hot topics."

When the Ohio Legislature does reconvene, look for accountability bills, left pending at the end of this year's session, to be reintroduced. The access issue is also likely to be on the Legislature's new slate. One possibility is a POS bill, to be introduced early in 1999.

OSMA is proud of its role in the passage of the Physician-Health Plan Partnership Act, and continues to support state initiatives for practice reform that support both physicians' roles and patients' rights. – Yvonne Barry

Medical Board report

Board ponders whether PA scope should include deliveries

Should a physician assistant (PA) who is a certified midwife be permitted to perform low-risk vaginal deliveries?

This request, in the form of a supplemental plan from a Central Ohio obstetrician-gynecology practice, presented a double-barrel question to members of the State Medical Board at a late summer meeting: 1.) Are low-risk vaginal deliveries within the scope of practice of PAs and 2.) Is the board authorized to license PAs to do obstetrical care?

The PA in question is not a nurse. Her midwifery education was gained through a home-study course and a required preceptorship with a certified nurse-midwife (in collaboration with supervising physicians) as well as an experience level of 25 deliveries. At present, there is no regulatory agency that has jurisdiction over midwives.

Assistant Attorney General Anne Strait told the board that its first duty is to decide whether or not low-risk deliveries fell within the scope of practice of a PA. Then it could make the decision as to whether or not this particular PA is qualified by her training and practice to do low-risk deliveries within the plan presented by the supervising physicians.

The board wrestled with both issues. One board member expressed hesitation at opening the door for other PAs to take additional training (i.e. administering anesthesia), then to come to the board to expand their scope of practice. And the board simply felt uncomfortable licensing someone to perform midwifery. If she wants to practice midwifery, a board member said, let her do it through direct entry midwifery and not through her role as a PA.

Board members recognized, throughout their discussion, that this request was precedent-setting. Much discussion went into the qualifications of a midwife, especially in view of the fact that, according to one board member, a reported 15% of low-risk preg-

Medical Board Report

nancies have problems during delivery.

The board finally agreed it had jurisdiction over whether or not it should expand the PA's role as requested. As a result, it adopted the following statement, with regard to the proposed order:

"The training and experience acquired by physicians in the course of medical school and residency training is far more extensive than that which a non-nurse physician assistant can obtain to deal with the complications that may arise out of routine, low-risk, vaginal deliveries. (The PA's) certification as a midwife does not rise to the level necessary to qualify her to perform the procedures requested in (the) supplemental plan in her capacity as a physician assistant. It is hereby ordered that the supplemental physician assistant utilization plan...is hereby denied."

Of note...

Budget process...The board voted to proceed with proposed budget projections that would include, if approved by legislators, a \$30 fee increase for medical licenses for MDs, DOs, and DPMs.

Waiving English proficiency test...Board members took another possibly precedent-setting stand when it agreed that an applicant who had trained in the United States would not have to demonstrate English proficiency through the Test of Spoken English (TSE). The applicant stated that physicians who have been licensed in another state during the preceding five years do not have to take the TSE. The applicant submitted that the TSE waiver does not have to be applied only to

physicians with a full and unlimited license. The board agreed that a license — including a training license or temporary license — qualifies a physician to ask for a TSE waiver. The applicant's request for endorsement licensure was granted.

Work on rules continues...The board continues to work on a variety of rules, including the physician emeritus rule, which would allow retired physicians to claim a "nonpracticing physician" status, and impairment rules. The Impairment Committee is also meeting with the Drug Enforcement Agency about an appropriate way to handle the DEA license in board orders and consent agreements. Finally, the board's Prescribing Committee continues to work on rules resulting from Senate Bill 66, which allows pharmacists to enter "consult agreements" with physicians. In these agreements, the phar-

macist is given the authority to modify the physician's prescription with respect to dosage and form. The Medical Board and Pharmacy Board have the joint responsibility to arrive at appropriate language for the contract.

The OSMA has provided its input to the board in this process. ■

Don't miss out

Have you visited the OSMA's Web site lately? If not, you may be missing the latest news. The site is updated every Tuesday and Friday. Visit often for the latest Ohio health-care news.

www.osma.org

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Dateline Ohio

Seniors to test market booklet about Medicare's health options

Ohio is one of five states chosen to test market a new booklet designed to tell seniors about Medicare's health-care choices. The information is scheduled to reach your patients sometime this month – between Election Day and Thanksgiving – and is the Health Care Financing Administration's attempt to make the options available to Medicare patients easier to understand.

The government's goal is to place more seniors in managed-care programs, such as its own Medicare Plus Choice, and to privatize the Medicare system as much as possible. Unfortunately for the government, its timing couldn't be worse.

This summer, Anthem Blue Cross/Blue Shield announced plans to withdraw its Medicare HMO product from 22 rural Ohio counties, and Aetna U.S. Healthcare reported recently that it would discontinue its Medicare managed-care programs in six states (Ohio

isn't one of them). Although Anthem is reportedly reconsidering its decision, Ohio's 1.73 million seniors may be wary of trusting other managed-care products that are "here today and gone tomorrow."

Still, that's unlikely to stop your patients from receiving a deluge of advertisements and marketing material sent by insurers who find the rapidly-growing senior marketplace a financially attractive business opportunity.

Currently, more than 15% of Ohio's seniors are enrolled in the 21 Medicare managed-care programs offered in Ohio. That's a growth of about 4% from 1996, when only six Medicare products were available.

That means competition among ex-



Ohioans will test market a new booklet designed to tell seniors about Medicare's health-care choices.

isting Medicare HMOs is likely to pick up as well. Whether or not HCFA's booklet will clarify managed care for seniors is uncertain. What is certain is that you can expect to see more changes in this marketplace as the Medicare managed-care trend continues to develop. ■

ODH appoints new director

William Ryan, the first non-physician to serve as director of the Ohio Department of Health, has resigned his position and accepted a post as vice-president of OHA: The Association for Hospitals and Health Systems. He



William Ryan

assumed his new role last month. Ryan will manage strategic issues for the OHA, and is likely to be involved in such subjects as health-care access and telemedicine. Ryan had served as ODH director since May 1, 1997.

The new ODH director is Lou Ellen Fairless, whose previous position with the department was assistant director in charge of programs. She has been with the department since 1993, and has more than 20 years experience in public and private sector health organizations, including programming at Harvard University's Kennedy School of Government. She is a graduate of West Virginia Wesleyan College, and has a master's in social work from West Virginia University. ■

Law firm sued for its part in PIE collapse

The Ohio Department of Insurance (ODI) has filed suit against a Cleveland law firm, charging it with legal malpractice in its dealings with PIE Mutual Insurance, and requesting at least \$10 million for its role in the insurer's collapse. PIE was declared insolvent, and went under state control last December.

The suit says Benesch, Friedlander, Coplan and Associates conspired with former PIE Chief Executive Larry Rogers to conceal PIE's financial condition from PIE board members and state regulators, enabling the failing company to compound its losses. The ODI is also asking for a return of

\$867,000 in legal fees.

Benesch responded by filing a law-suit that seeks the removal of Harold T. Duryee, ODI director, as liquidator. According to the law firm's suit, Duryee has a conflict of interest in all matters relating to PIE because his former deputy, David Randall, admitted to taking bribes from PIE. In return for gifts, such as air travel and use of a vacation home, Randall helped hide PIE's failing financial strength.

More recently, the ODI has also sued 24 former PIE Mutual Insurance board members and executives for their "reckless disregard for the com-

pany's best interests." The suit asks for more than \$40 million – at least \$20 million from former PIE President Larry Rogers. According to the suit, PIE directors enjoyed lavish parties, failed to investigate the payment of extravagant bonuses and salaries to officers and permitted financial mismanagement and conflicts of interest – all at the expense of the company's financial strength. When PIE was liquidated in March, liabilities exceeded assets by at least \$275 million. ODI's action is an effort by the department to raise money to pay claims against the failing carrier. ■

AIDS comes to Noble County

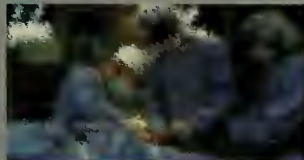
Noble County, the last Ohio county to have no reported cases of AIDS has notified the Ohio Department of Health (ODH) of its first case.

The case was diagnosed in 1996, but not reported until this year because of some delay in the process.

Although this is the first reported case, it is possible that other AIDS cases were diagnosed in the county but not reported, or that individuals who tested anonymously for AIDS moved outside the area for treatment. ■

Protection... or Poison?

Commonly referred to as an allergy, increasing numbers of medical professionals are coming to recognize that latex sensitivity is more accurately likened to toxicity. As a result of unreasonably high protein levels in some latex gloves, a number of physicians and health care professionals have been poisoned by a product that was promised to protect them. Consequently, their careers are in jeopardy.



You may already be among this group, or you may soon find yourself a member of the growing number of medical practitioners who are latex sensitive. Latex allergy is changing the practice of medicine. For a more complete understanding of the allergy -- its history and ramifications for both physicians and patients, visit our website at www.latexallergy.net.

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Latex Allergy...The Growing Threat

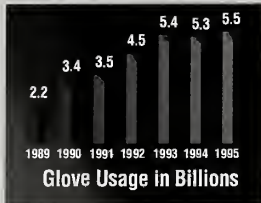
Latex glove usage more than doubled between 1989 and 1995 with the adoption of the Universal Precautions. At the same time, in an effort to speed up production and meet the spike in demand, some glove manufacturers may have taken production shortcuts that resulted in gloves hitting the market with dangerously high allergenic protein levels.

As the body absorbs the latex proteins, the immune system may become increasingly sensitive to the protein allergens, although the user is often unaware of

this as it is occurring. Over a one to three year period, however, the medical professional may suffer progressively severe symptoms. Symptoms that may drive the professional from his or her career.

"The most effective strategy in treatment of latex allergy is avoidance; however there is a large group of sensitized people who have not been identified and who do not recognize their symptoms are caused by latex allergy."

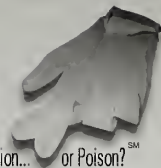
Latex allergy. S. Reddy, *American Family Physician*, Jan. 1998, 57(1):93-102.



- A Bibliography of Additional References
- Current Statistics on the Impact of Latex Allergy
- Clues to Identifying and Diagnosing Symptoms of Latex Allergy
- Information on Various Support Groups
- A List of Common Items Containing Natural Rubber Latex

The law firm of Clark, Perdue, Roberts & Scott represents Ohio physicians and healthcare professionals in actions against those latex glove manufacturers who failed to remove the dangerous proteins from their gloves and also failed to warn users of the dangers. If you, or one of your colleagues, suffer Type I latex allergy symptoms, we urge you to take this threat to your career seriously. You could have a product liability claim, but you may need to act quickly. You may need to file a claim in court within two years from the date you knew, or should have known, that you were injured by the latex gloves. If you fail to file a claim on time, you may lose your right to do so in the future – no matter how seriously your symptoms may progress, or how drastically your career is altered.

If you'd like more information simply to explore your legal rights and remedies in confidence, we invite you to contact CPR&S partner, Douglas S. Roberts.



www.latexallergy.net

We have compiled an extensive body of information on the topic of latex allergy at our website. At www.latexallergy.net you will find:

- Case Studies of Professionals Whose Lives and Careers Have Been Forever Changed Since Becoming Sensitized to Latex
- Excerpts of Relevant Journal Articles
- A List of Manufacturer's Contact Numbers For Determining Latex Content in Specific Products
- Links to Other Latex Allergy Websites
- A Basic Quiz To Test Your Sensitivity to Latex
- Latex Allergy Alert News Bulletin Subscription



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Specialty news: Surgeons

Campaign strives to end "wrong-site surgery"

The American Academy of Orthopedic Surgeons has launched "Sign Your Site," a national education program that encourages surgeons in all medical specialties as well as other health-care providers and hospitals officials to implement effective controls to eliminate wrong-site surgery.

The Academy's Advisory Statement on Wrong-Site Surgery recommends the operating surgeon:

- Discuss the surgery with the patient before anesthesia;
- Place his or her initials on the operative site, using a permanent marking pen;
- Operate through or adjacent to his or her initials.

The statement also includes recommendations for specific actions to be followed if the surgeon discovers that he or she is performing or has performed wrong-site surgery.

The materials were developed by the Academy's Task Force on Wrong-Site Surgery. According to that group's

Executive Summary, the Physician Insurers Association of America (PIAA) documented the incidence of wrong-site surgery for 1985-1995 with data collected from 22 member medical malpractice carriers, insuring 110,000 physicians. During this period, 106 of 331 closed claims were submitted for wrong-site surgery incidences occurring in nonorthopedic procedures, with an average pay-out of \$76,167. In orthopedic surgery, 84% of wrong-site surgery resulted in payment.

Reviewing the wrong-site surgery records of one carrier, the task force learned that most cases resulted from surgeon error, or an incorrect site was prepared and draped by operating room staff. In some cases, the cause of wrong-site surgery was traced to the patient's incorrect identification of the surgical site, or a documentation error made on the operative permit or preoperative radiograph.

Other reports indicated mistakes also occurred when: General anesthesia had been administered; the surgeon was not in the operating room for in-

duction of anesthesia or preoperative preparation; the surgeon was in a hurry; there was prone or lateral positioning of the patient, which proved disorienting for the surgeon; incorrect labeling of X-rays; flipped X-rays; and in the case of wrong-site spine surgeries, over-reliance on unreliable techniques for identifying and marking the appropriate disk levels.

The task force report, "Report of the Task Force on Wrong-Site Surgery," specifically details the orthopedic wrong-site surgery closed claims including information on the anatomical site, type of surgery performed, time of discovery of the wrong-site surgery and subsequent action after discovery. The report is available on

the Academy's Web site, www.aaos.org/wordhtml/meded/tasksite.htm.

Take Action

A copy of the Advisory Statement on Wrong-Site Surgery can be obtained by calling Emily Katke at the American Academy of Orthopedic Surgeons (847) 384-4126. The Advisory Statement is also in the "library" section of the Academy's home page, www.aaos.org, and fax-on demand (800) 999-2939, document number 1015. Or, OSMA members may call the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for item #35-98.

Health groups want tobacco settlement monies

If Ohio receives a predicted \$8 to \$12 billion from tobacco companies as settlement for the state's lawsuit against them, then at least one-third of those funds should be used to prevent tobacco use, says several health groups. "Or we will be back in the same situation 25 years from now," says Don McClure, chair of Tobacco-Free Ohio.

Tobacco-Free Ohio joins the American Cancer Society, Ohio Division; the American Heart Association, Ohio Valley Affiliate; and the American Lung Association of Ohio in suggesting that prevention efforts could include educational programs, increased enforcement, cessation programs and counter-marketing, especially with children.

In a letter to legislators, the groups write: "Statistics show the smoking rate among adults decreases dramati-



cally when prevention is taught during adolescence." The letter continues that Ohio has not earmarked money specifically to prevent children from starting, "this addictive and potentially fatal habit."

Any money received in the settlement will be dispersed by the Ohio Legislature. Funding public health programs is likely to be at the top of legislators' priority list when it comes time to direct the placement of settlement funds. ■

Court upholds doctor's license suspension

The Franklin County Court of Common Pleas upheld the decision made by the State Medical Board of Ohio to suspend the license of Toledo-area pediatrician Gary F. Gladieux, MD, for having sex with several of his patients' mothers. Last year, the board suspended Dr. Gladieux's license for a minimum of two years.

The board's decision was unprecedented because, although Ohio law and the AMA's Code of Ethics prohibit a doctor from having sex with his or her patients, there are no known guidelines regarding sexual relations with a minor patient's parent. Dr. Gladieux, who is married and the father of three children, admitted to having sex with seven of his patients' mothers. He told the board that the sex was consensual, and his attorney argued to the court that the board had exceeded its authority by imposing a sanction against a doctor for private conduct.

But Judge Dale A. Crawford said in his ruling that the parent is often an integral part of the child's treatment regiment, and should be treated in the same professional manner as the patient.

If Crawford's ruling is upheld through a likely appeals process, the board will enforce the license suspension it ordered in 1997. Crawford issued a stay on the board's order last December when Dr. Gladieux's suit was filed with the court. The doctor, who has since moved from Toledo to Swanton, has been allowed to continue his practice, although he must meet certain conditions filed by the court, including notifying families of current and new patients that he has been suspended for violating the AMA's Code of Ethics. ■

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Forum

Jury still out on physician exemption waiver

Doctors don't like jury duty.

In September, *Ohio Medicine* included a fax-back form on which OSMA members could respond to (Ohio Supreme Court) Chief Justice Thomas Moyer's editorial on why physicians should serve on juries. Respondents disagreed with the Chief Justice by a ratio of 4 to 1.

Why they disagreed

As might be expected, most respondents were concerned about the effect jury service would have on patients and families. One member wrote, "I have no time to take care of the sick and participate in jury duty. Although legal cases may be interesting, I'd rather practice medicine."

And a solo general surgeon wrote: "Patients expect that when a surgery is scheduled, there are no changes in that scheduled time." Another wrote, "The legal system is not harmed if physicians are not on juries, but physicians (and their patients) would be harmed if they served on juries."

One member, who has already been called to report for jury duty, confirms that the process is disruptive. He was told to report in three weeks, but, as with many physicians, his time had already been scheduled six to eight weeks out. In fact, on the date he was scheduled to report, he had four surgeries to perform. He was excused.

Another doctor who was called for jury duty at the end of June was able to receive a deferral until mid-October. But, he writes, "I will have to close my practice at least one week."

A third respondent indicates he served on jury duty for three weeks — which created a hardship for him as well as for his patients.

Because physicians are typically

employers as well, a number of respondents indicated they would have to close their offices and temporarily lay off employees while they served.

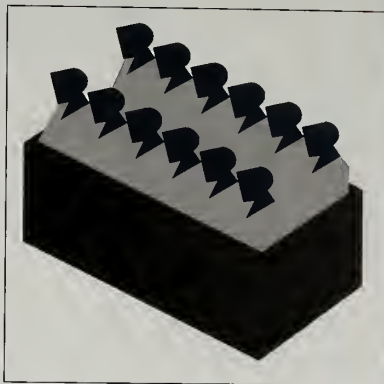
Another member questioned the ethics of canceling a surgery that was already scheduled, and another worried about the legalities of canceling or postponing surgeries that have been authorized by a contract payor, like an insurance company.

And do physicians really reflect the community? One member noted that the relatively small number of physicians only marginally reflects the community and that the physicians' level of education doesn't reflect the vast majority at all.

Besides, many of the members who responded to Chief Justice Moyer's editorial don't believe that lawyers are inclined to seat them on juries.

"What lawyer would want me on a jury panel, since I'm surely involved in legal disputes?", asked one respondent. Another wrote: "If Justice Moyer thinks that juries should reflect the community, he must change the attitude of the legal profession. Every lawyer I told I was on the jury panel laughed and said there was no way I would be selected because 'I thought for myself' and thus would not be chosen to serve on a jury."

Another added: "Doctors are skepti-



cal of the legal process."

Why they agreed

There were some members, however, who believed Chief Justice Moyer had a point.

"Professionals must serve," wrote one doctor. "Juries arrive at erroneous conclusions due to lack of professional input." Another respondent said juries need individuals who can think through a problem, and not be swayed by emotions in a courtroom. "Physicians would add balance," he said, but he agreed with other respondents who wrote that lawyers are unlikely to select physicians to sit on juries. "Picking juries is a science — and big business," he added.

Several respondents were brief, stating all should serve on juries although some added that their willingness hinged on a more efficient system, or

Dispelling the myths

There are a couple of misunderstandings about jury service that were raised by the responses.

Several doctors noted that, if physicians are called to serve, lawyers should be called to serve as well. In fact, the law that waived doctors' exemption from jury service also eliminated exemptions for lawyers. (Incidentally, lawyers have the same thought as doctors... "Who would want me on their jury?")

Many respondents expressed concern about the hardship jury service would pose for their practices and their patients. It should be noted, however, that courts are still able to excuse jurors from service if they meet one of several criteria. The OSMA believes the most likely ground for exemption for physicians is the one relating to your interests and the interests of any other (i.e. patients) who are materially affected by your service on a jury. Just because you are called for service doesn't mean that you can't ask to be excused, or ask for a deferral, as one respondent did.

One doctor noted that he would give up his voting rights, regrettably, so he wouldn't have to serve. At present, most courts do call their jurors from voting lists, but according to the Ohio Revised Code, potential jurors should be drawn from a jury source list compiled from one or more regularly maintained lists of persons residing in the court jurisdiction. Traditionally, jurors have been pulled from voting lists, but there has been some discussion about using other lists in the future, including drivers' lists.

Finally, because the subject was raised by a number of respondents, *Ohio Medicine* will explore in a future issue exactly what your chances are of being seated by a defense team once you've been selected for jury service. Watch for it. ■

continued on page 13

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We've earned the confidence of over 16,500 physicians



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Jury...

continued from page 11

proper compensation.

One physician wrote that he would want other physicians on a jury if he were involved in a malpractice case.

Two respondents, however, supported the move to include physicians on juries without any conditions. One simply stated that physicians should serve and he looked forward to being called...the other agreed that jury service would be an inconvenience, but the importance of the duty outweighs the inconvenience. "I am concerned about the absence of business and professional people on juries," he wrote.

Suggested changes

Although there were responses that called for a return of the exemption waived by the new law, some members tempered their opposition with suggestions on how to make the procedure more palatable.

First, a number of respondents had no objection to serving on juries once they were retired, or if they had jobs that did not relate directly to patient care. OSMA members offered the following suggestions:

- Shared jury assignments.
- Professional juries (the assumption is career jurors as opposed to juries composed entirely of professionals.)
- Giving physicians the option to serve.
- Providing doctors other ways to serve their communities.
- Eliminate jury service and replace the system with an advisory panel that would objectively review the evidence in a case and would then advise a judge-panel. The judge-panel would issue the verdict. "This removes subjectivity," the member wrote.
- Extended, advanced notice of an exact time commitment.
- Use beepers to call jurors when they are needed.
- Request that potential jurors submit the prior year's tax return, "then pay us for our jury service at a pro-rated portion of our annual salary."
- Allow anyone called to jury duty to send a substitute of his/her choosing. Whether or not the proxy would be paid would be a decision between the individual called and the substitute. ■

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OSMA News



OSMA survey profiles group practices in Ohio

Each year, the OSMA distributes a group practice survey in order to keep current with the demographics of this rapidly-changing population. According to Susan Rupli, who staffs the OSMA's Group Practice Section, there is more to the survey than just determining group location and size. The questionnaire also probes into group structure, benefits and compensation.

"One of the reasons we distribute this survey is to determine who our group members are and how we can better meet their needs," says Rupli. Of course, surveys don't provide all the answers. That is why she is on the road a good part of the year, meeting with groups and group managers, to explain the benefits and services of membership in the OSMA. Sometimes, she travels solo, other times in tandem with other OSMA staff members – like legislative director Tim Maglione or the association's Northeast field representative Ben Reynolds.

"The OSMA can help groups in a number of ways – whether they're in urban or rural settings – but first they need to know we're out there, then they need to know what kinds of services we can provide them," says Rupli.

Group practices change rapidly in Ohio. Few of the reported "Super-groups" (large practices merged with other large practices) have emerged, and mid-size groups and small groups dominate the scene.

"We've learned, though, that size of groups can change rapidly – and with that, their problems," says Rupli.

"That's why we conduct this survey annually."

Here is a quick review of this year's survey results – a profile of group practices as they exist currently in Ohio.

• Number of physicians in group	
1-10.....	85%
11-20.....	9%
20-30.....	2%
40-50.....	3%
65.....	1%

• Specialty	
Multiple.....	14%
Single.....	86%

• Legal organization	
Professional corporation.....	88%
Physician owned.....	27%
501c3 nonprofit.....	4%
Other.....	6%

(Groups could check more than one response)

• Physicians compensation structure	
Salary + bonus.....	48%
Productivity.....	24%
Productivity + bonus.....	12%
Straight salary.....	5%
Other.....	11%

• Benefits offered by the group to its physicians	
Shared on-call coverage.....	100%
Health insurance.....	99%
Malpractice insurance.....	99%
Professional dues.....	96%
Paid vacation.....	94%
Continuing medical education.....	93%
Life/disability insurance.....	90%
Maternity leave.....	49%

• Number of practice locations	
1-5.....	85%
6-10.....	10%
11-15.....	5%

• Estimated number of capitated or pre-paid patients	
0-100.....	20%
200-500.....	20%
500-1,000.....	6%
1,000-5,500.....	32%
5,500-10,000.....	6%
11,000-above.....	16%

Alliance Fall Focus addresses managed care

What does managed care do to physicians and their practices? How does it impact the medical family – and what can Alliance members do about it?

Managed care is just one of the topics to be presented Nov. 17-18 at the OSMA Alliance's "Fall Focus" meeting, to be held at the Adam's Mark Hotel in Columbus.

OSMA President Lance Talmage, MD, will serve as the Alliance's keynote speaker, presenting his address at 9 a.m. Wednesday, Nov. 18. The managed-care program follows. Other topics include: Children of Violence; programs that work (including tobacco compliance checks and mentoring) and working with the media.

If your spouse would like to attend but hasn't registered yet, she or he should contact Deborah Blackwell, OSMA Alliance office, (800) 766-6762, Ext. 6750 for more information. ■

Two named to AMA's CPT panel

OSMA member Craig Stafford, MD, and William E. (Bill) Fry, director of the OSMA Department of Ombudsman Services, are new appointees to the AMA's Current Procedural Terminology (CPT) panel, which will provide technical assistance as the Health Care Financing Administration seeks to update its E&M documentation guidelines (for an update on that process, see the story on page 1.)

Dr. Stafford, an obstetrician-gynecologist who practices in Gallipolis, accepted the appointment to the Executive Project Advisory Group (PAG), that will assist in development of CPT-5. He has served on the AMA Group Practice Advisory Committee for several years, has chaired the OSMA Group Practice Section, and previously taught coding for the College of Obstetricians-Gynecologists.

Bill Fry, who worked for the "Blues" prior to taking his position at the OSMA, is well-known by OSMA members as a trusted reimbursement adviser. He has been appointed to the CPT Workgroup on Maintenance and Education.

The current version of CPT is one of the core information standards upon which the health-care industry relies for administrative, financial and analytical purposes – but it may not remain the standard.

As reported in two recent issues of *AMNews*, the federal government is charged with selecting a national standard code set for reporting physicians' services under the "administrative simplification" provisions of the Health Insurance Portability and Accountability Act of 1996. And the CPT system, developed by AMA in 1966, and now updated annually with broad input from

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CPT panel...

continued from page 14

medical specialists and quantifying professionals throughout the health-care industry, may not be the standard selected.

CPT proponents, including the "resounding endorsement" of all 50 state medical societies, cite clinical appropriateness and the cost of change as reasons for keeping the present system. "Critics," according to *AMNews*, "are concerned with AMA copyright, faulting the CPT arrangement as an 'exclusive government-granted monopoly' that has created a 'dependency on government agencies.'"

Even without this particular controversy, Dr. Strafford explained that the CPT code revision and update decisions on the table could require a broader "evolution or revolution" decision up-front. Current issues include managing quality assurance, accommodating telephone consultations, and instituting an alpha-numeric system to simplify the necessary growth in the number of codes.

According to the AMA Web site, the CPT Editorial Panel, which reports directly to the AMA Board, addresses nearly 350 major topics each year, which typically involve more than 3,000 votes on individual items. —
Carol Larimer

Take Action

Guidelines for suggestions for changes to the CPT code are available at www.ama-assn.org/med-sci/cpt/process.htm. Depending on how for each suggestion goes, the multistep process can take many months, so observing deadlines and procedures is paramount. AMA staff responds to each suggestion, regardless of outcome. Coding change request forms to introduce new procedures or to delete or revise procedure codes already in the CPT book are available upon request from the AMA Department of Coding and Nomenclature. The AMA's general number is (312) 464-5000.

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New pain rules effective Nov. 11; OSMA' pain handbook due soon

Pain – The Fifth Vital Sign, the pain management handbook developed by the OSMA's Ad Hoc Committee on Pain Education, is due to be mailed within the next several weeks and should be in your hands before the end of the year.

The handbook will be distributed to all Ohio physicians, as mandated by Senate Bill 187 (SB 187), the pain control legislation. The OSMA agreed to develop and mail the handbook not only because of the importance of the issue but also because, in return, the Legislature agreed to drop language from the bill that would have required all Ohio physicians to obtain two hours of CME credit on pain management.

The manual looks at recommended clinical approaches and offers recommendations for managing chronic pain, and will offer physicians two hours of Category I CME credit. The printing and mailing of the handbook was supported by an unrestricted grant from

the Roxane Pain Management Institute.

SB 187 also required the State Medical Board of Ohio to adopt rules establishing standards and procedures for physicians in the diagnosis and treatment of intractable pain, including standards for managing intractable pain by prescribing, dispensing, or administering dangerous drugs in amounts that may not be appropriate when treating other medical conditions.

The board has finally issued its new rules on the treatment of pain. The rules go into effect Nov. 11. ■

Take Action

For a copy of the intractable pain rules, visit the "News Roundup" on the OSMA Web site, www.osmo.org or call the State Medical Board of Ohio, (614) 728-3673 or the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580. Ask for Item #36-98

OSMA Ad Hoc Pain Education Committee

The following OSMA members comprise the OSMA's Ad Hoc Pain Education Committee which developed and produced the pain management handbook. You should receive the handbook in the next several weeks.

Robert D. Gillette, MD, Poland; Warren Wheeler, MD, Columbus; Constantino Benedetti, MD, Columbus; Eric M. Cheyten, MD, Youngstown; Mark Boswell, MD, Cleveland; Thomas Vetter, MD, Akron; Thomas E. Greter, MD, Cleveland; David Dawdy, MD, Westerville; Jay C. Williamson, MD, Rootstown; Bill Bauer, MD, Bellevue

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On the Web...

A link to useful sites

The OSMA Web site has a new, re-designed links page. Now, instead of scrolling through a long list of sites, you'll find what you're looking for, divided into helpful categories: county medical societies; government agencies (state); government agencies (national); specialty societies; selected media; local insurance/ managed-care organizations; malpractice insurance rating services; and other useful links.

While you may have many of these sites bookmarked – Ohio Bureau of Workers' Comp, State Medical Board, Ohio Department of Human Services – wouldn't it be easier to just call up the OSMA site and have all this information at your fingertips?

The media list includes hyperlinks to the *Akron Beacon Journal*, *Cincinnati Enquirer*, *Cleveland Plain Dealer*, *Columbus Dispatch*, *Dayton Daily News*, *Toledo Blade* and *Gongwer News Service*, so grab a cup of coffee and check the news around the state, without that messy newspaper ink. Or if you prefer snippets of national news headlines before you start the day, click on *USA Today*.

Last month, *Ohio Medicine* featured an insert with the ratings for the professional liability insurance carriers. It was recommended in that article you check the ratings on your own between the quarterly inserts in *Ohio Medicine*. The Web site gives you a direct link to A.M. Best, Standard & Poor's and Weiss ratings services, so you can do just that.

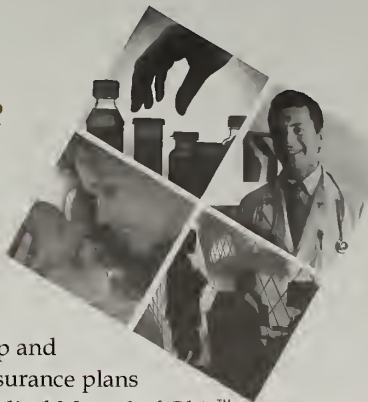
The links page is a work in progress. If you have suggestions or additions for the page, let us know. E-mail Karen Kirk at: kkirk@osma.org.

Cyber sweepstakes

You still have time to enter the OSMA cyber sweepstakes. If you send us your e-mail address by Dec. 4 you'll be entered in a contest to win a night's stay at the Hyatt Regency Cincinnati plus dinner for two at Champ's Restaurant. Send your e-mail address to: kkirk@osma.org; call (800) 766-6762, Ext. 6754 or fax (614) 527-6762. ■

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OSMA Profile

A demographic look at your association.

Ohio medical student graduates

Ohio has six allopathic medical schools and one osteopathic medical school. A number of those who graduate from these institutions not only choose to stay and practice in Ohio, but also to become a member of the OSMA as well.

In fact, about 43% of all OSMA members graduated from Ohio's medical schools. Here is how the statistics break down:

Total number of OSMA members who graduated from Ohio medical schools: 4,342.



Ohio State University College of Medicine.....	1,717 (39.54%)
University of Cincinnati College of Medicine.....	1,040 (23.95%)
Medical College of Ohio at Toledo.....	493 (11.35%)
Case Western Reserve University School of Medicine..	447 (10.29%)
Wright State University School of Medicine.....	279 (6.43%)
Northeastern Ohio University College of Medicine..	202 (4.65%)
Ohio University College of Osteopathic Medicine....	164 (3.78%)

(Numbers in parentheses are the percentage of Ohio grads.)
Source: OSMA Electronic Data Processing Department

Association supports Patient Bill of Rights

The state's managed-care reform law (the Physician-Health Plan Partnership Act) is now a month old. That's too soon to tell, of course, exactly how the law has impacted your practice, but it will have a positive effect eventually — you can count on it.



Lance Talmage, MD

The OSMA worked hard to make these improvements for Ohio patients and their physicians, and we'll continue to work to ensure that, no matter what form the marketplace may take, the physician-patient relationship is preserved.

As you know, Congress is considering a Patient Bill of Rights that carries the protection issue further. Both the AMA and the OSMA have taken the rather unusual position of supporting the Democratic-backed Dingell-Daschle bill over its Republican counterpart.

It's unusual for organized medicine to back a Democratic bill but, like politics, managed care creates strange bedfellows. The point is, as patient advocates, we must support the bill that offers the most protection for our patients, and, right now, that's the Dingell-Daschle bill.

Organized medicine believes there are several key elements that must be included in any patient rights bill. In fact, most of these were included in our own PHPPA. They include:

- Ensuring that a patient has the right to quickly appeal the denial of health-care coverage by a health plan;
- Full disclosure of what services are and are not covered by an individual's health insurance;
- Establishing a "prudent layperson" standard for individuals seeking medical treatment in an emergency; and
- Prohibiting gag clauses in contracts.

President's Perspectives

The key difference between the Dingell-Daschle bill (S. 1890) and the bills offered by Republicans (S. 2330), and a bipartisan team (S. 2416) is that the last two legislative measures do not contain any provisions that hold managed-care plans accountable for the health-care decisions they make. Organized medicine thinks that's an important point to include — and the Dingell-Daschle bill includes it.

Currently, Ohio has several bills pending at the Statehouse on the issue of managed-care accountability, but enactment of a federal bill would make state legislation unnecessary. That's one reason why we support S. 1890.

The other reason is that federal legislation would offer protections for all patients. Right now, the PHPPA and even the state managed-care accountability bills that are pending fail to cover those Ohioans whose employers provide them with ERISA-exempt health insurance. That's about 50% of our patients.

If the Patient Bill of Rights fails to pass, the AMA is likely to seek out and support federal legislation that waives the ERISA exemption, and promotes the accountability issue as well.

The OSMA has made great strides with PHPPA. Now, organized medicine hopes to see the same kind of progress on the national level. It's doubtful there will be action on this bill in the next few months, but it will resurface next year. At that time, we will need your support. I encourage you to contact your Congressional representatives and let them know how important this bill is to our patients. ■

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Practice Tips

Year 2000...Is your office system ready?

Editor's note: The medical profession is as dependent on technology as any other profession these days. As the millennium approaches, that technology may result in some major problems for you and your patients as everything digital threatens to become incapacitated by the "00" date. This is the first of a series of columns that will attempt to bring you up-to-speed on the kinds of things you need to pay attention to as the year 2000 approaches.

Unless you live on a mountaintop and are completely self-sufficient, you will want to be Y2K-savvy very soon. The future of your business depends on it.

Everything digital that has a microprocessor or clock in it must be checked for Y2K compliance. And every business with which you have a relationship should be able to assure you that they are Y2K compliant — while you still have time to arrange alternative vendors and incorporate their services into your back-up plan, if necessary.

Starting now is important for several reasons. First, for "just" your hardware and software compliance assessments, possible upgrades or replacements, data conversions and testing, you will want to check any warranties or contracts that may require you to use a particular vendor. That vendor, or another of your choice, will probably be very busy already. In fact, some technical companies have full calendars through 1999, and unemployment for database programmers and network specialists is only about 2% in Ohio, according to Chris Foley, vice president of sales for the Invisible Network division of AccuNet, Inc., based

in Columbus.

According to Foley, "Very soon, with increasing Y2K-compliance awareness, you will have to 'take a number' for computer services of any kind."

He also said there are a number of potential "gotcha" dates out there — not just 1/1/00. For instance, the date 9/9/99 is a traditional null value, used for testing computer systems; consequently, some older systems may not recognize it as a valid date. For the same reason, and depending on how a system tracks days in a year, the date 4/9/99 may not be recognized (it's the 99th day of '99). The leap-year date, 2/29/00, may not have been accounted for, and if it wasn't, your system may also not recognize the 366th day of that year (12/31/00). Even if a system makes it through 2000 without any glitches, some systems are expected to revert to 1901 on 1/1/01. And, while we're at it, we might as well deal with the year 2038 — when some binary counters will exceed their capacity and roll over, posing a whole new host of problems.

Foley estimates that a typical medical office has between 5 and 10 computers, some UNIX-based, and some PCs. Each component, server and operating system must be assessed alone, and also when integrated. "No software is warranted against bugs, and that's what the Y2K threat is — a bug," according to Foley.

"Many people don't realize that their hardware must also be assessed. Whenever a system is turned on, the date and time are generated by the software from the hardware."

Some software and hardware manufacturers allow you to check the compliance of their components by serial

number and manufacturing date, on their Web sites. According to Foley, 286s, 386s, and some 486s typically cannot be upgraded to compliance level; usually Pentiums already are.

His advice: "Educate yourself now. Expect problems, be prepared, and be wary. There is no 'one fix.' If your CPA is also your business adviser, and has some technical knowledge, that person would probably be a good partner for auditing your system."

That sentiment is echoed by J. Clarke Price, president of the Ohio Society of Certified Public Accountants. "Your CPA usually knows more about your business than any other outside adviser, and was probably involved in the original selection of your computer system," says Price.

"During your annual audit, you should tell your accounting firm, 'Challenge us. Where might we be vulnerable?'"

"Even if an office doesn't experience total meltdown, any disruption will be costly. Conducting a complete Y2K audit of all your digital systems and requiring due diligence from your suppliers are wise investments. The threat will also serve as a reminder to be vigilant with any new purchases."

The nonprofit Industrial and Technology Council of Central Ohio has an economic development role, to help all kinds of businesses find the processes and tools for doing things better, says President and CEO Frank Henson. This broad charge encompasses the life sciences and applied management theories, as well as technical resources.

Henson warns that "a number of subtle incompatibilities can be very

Before you tape that phone call...

It's not unusual, when you talk to an insurance carrier, to hear that your call is being taped and monitored for quality. What if you want to monitor the call at your end — can you tape, too? Yes, you can, says OSMA's Director of Legal Affairs Katrina English. But only if you follow certain guidelines.

Each state has its own laws for taping intrastate calls. If both you and the other party to your call are in Ohio, assuming that the call is not made to commit a criminal offense, you may tape the call without asking permission of or giving notice to the other party.

If you and the other party are in different states, however, the Federal Communications Commission's laws kick in. The FCC requires you to meet one of three conditions. You may make an interstate recording if:

- you have verbal or written consent from all parties to the conversation, or
- as the calling party, you inform all other parties that you are recording and record that notification as part of the call, or
- you use a tone warning device that automatically produces a distinct signal at regular intervals during the recording.

In addition, you must be able either to physically connect and disconnect the recorder from the phone line you use during a state-to-state call or be able to switch it on and off.

"A couple of physicians shared with us anecdotes," English says, "in which they said they told the party at the managed-care company, 'I'm recording this call for quality control purposes,' and they were hung up on by the reviewer. If that individual won't agree to be recorded, they're stuck. We need to spend some time with these outfits and say, 'Look, fair is fair.'" — Jan Leibovitz Alloy

continued on page 20

Y2K... continued from page 19

problematic, even if no special linking has been done. Do not take comfort in off-the-shelf software, whether used as stand-alones or a base package for a system.

Find a good technical company that focuses on small businesses and hire them — soon, is his advice. "There is need for concern. Small businesses are vulnerable, and probably less inclined than large businesses to seek help for Y2K compliance. Small businesses are much less likely to have the required specialists in-house, the preventive costs may represent a larger portion of their cash flow, and outside stockholders are less likely to exist.

"You will want to check your business liability insurance coverage, which may exempt business interruption due to Y2K. And, contract with your technical support organization for stand-by availability for the most critical dates, should your computers shut down or systems fail. Work with them on a specific emergency plan of action, such as who will call whom, and how you will recognize a Y2K problem, which will help minimize any problems.

"A thorough and careful Y2K compliance check is essential to every business' future."

No discussion of Y2K compliance would be complete without addressing liability issues. Computer, technical and Internet law happens to be one of the specialties of Mark C. Pomeroy, attorney with Columbus-based Bricker & Eckler LLP.

"Your primary Y2K-related goal should be uninterrupted operation of your business," says Pomeroy. "Look

for points of potential liability. For a physician, this will extend beyond your accounting system to patient records and medical devices that contain microchips.

"Make sure that all staff and group members are aware of risks and committed to your Y2K compliance goal.

"Recent Congressional hearings heightened the awareness that some medical device manufacturers are just now getting their acts together regarding Y2K compliance. Any medical office should look at their whole system, all vendors, and prioritize among them," Pomeroy continued. "Your source of certain medications is probably more important than your paper supplier, for instance. Request, in writing, a compliance statement from each. Talk with your most important suppliers by phone or conduct your own site visit, if possible.

"In some instances, we really are talking about a global commerce system. You are vulnerable to any lack of thoroughness on the part of your vendors, such as their distribution system, as well as their continued manufacturing capabilities. Arrange alternative sources for the most critical items.

"You will need a plan, with a schedule. This deadline is fixed. Even after all systems have been tested, both alone and together, you will need a contingency plan to cover your most critical areas. For instance, if electrical power is unavailable to keep certain medications within the proper temperature range, will you have dry ice or a generator as back-up?

"And you will want a disaster recovery plan. Remember that your landlord

is one of your most important vendors. Many systems in your building could be affected by Y2K incompatibility, from security and access/egress to telephone switches and elevators." — Carol Larimer

The following business resources generously contributed to this article — the first in a series on Y2K issues.

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- Industry & Technology Council of Central Ohio; Frank Henson, president & CEO, (614) 825-6085
- Invisible Network, division of AccuNet, Inc.; Chris Foley, vice president of sales (614) 899-9900, Ext. 111
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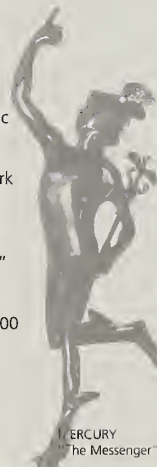
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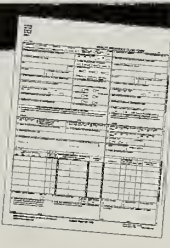
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WILLIAM H. ALLEN JR, MD, Athens, Case Western Reserve University School of Medicine, Cleveland, 1950; age 78; died June 28, 1998.

JEFFREY J. BERUS, MD, Bryan, Medical College of Ohio at Toledo, 1985; age 40; died Sept. 16, 1998.

SAMUEL GERSON, MD, Florida, Case Western Reserve University School of Medicine, Cleveland, 1937; age 88; died June 21, 1998.

JOSEPH I. GOODMAN, MD, Cleveland, Case Western Reserve University School of Medicine, Cleveland, 1932; age 90; died Sept. 18, 1998.

WILLIAM M. HEGARTY, MD, Gates Mills, Jefferson Medical College of Thomas Jefferson University, Philadelphia, 1942;

Obituaries

age 81; died Sept. 16, 1998.

RICHARD L. JACKSON, MD, Willard, Ohio State University College of Medicine, Columbus, Ohio 1953; age 73; died Aug. 16, 1998.

ELLIOT MARGLES, MD, Gates Mills, New York Medical College, New York, 1943; age 78; died Sept. 12, 1998.

AILEEN L. MAC KENZIE, MD, Chagrin Falls, University of Michigan Medical School, Mich, 1935; age 90; died Aug. 28, 1998.

HAROLD R. MAYBERRY, MD, Bryan, University of Cincinnati College of Medicine, Cincinnati, 1932; age 95; died Aug. 23, 1998.

LOUIS RYTERBAND, MD, Dayton, Registrable Qualification Granted By Scottish Conjoint Board, Scotland, 1939; age 86; died Aug. 26, 1998.

HERMAN I. ABROMOWITZ, MD, Dayton, and **CLAIRE V. WOLFE, MD**, Columbus, have received alumni achievement awards from The Ohio State University College of Medicine and Public Health. Dr. Abromowitz is a clinical professor of the Department of Family Practice and the Department of Community Health at Wright State University School of Medicine and is also a family practitioner at Franciscan Medical Center in Dayton. Dr. Wolfe specializes in physical medicine and rehabilitation at Mt. Carmel Medical Center in Columbus and is an assistant clinical professor of the department of physical medicine and rehabilitation at OSU.

ROSS BLACK, II, MD, Akron, has been named the family physician of the year by the Ohio Academy of Family Physicians. Besides his practice, Dr. Black teaches at the Northeastern Ohio Universities College of Medicine, volunteers at Akron's Open M free clinic and serves on the board of directors of the Portage Path Mental Health clinics.

Colleagues

ROBERT H. OSHER, MD, Indian Hill, and **ROBERT J. CIONNI, MD**, Montgomery, won first prize awards at the annual meeting of the American Society of Cataract and Refractive Surgery in San Diego. Dr. Osher created a video to demonstrate advanced surgical techniques for cataract surgery, and Dr. Cionni developed a device to help patients with challenging traumatic cataracts. They both work at the Cincinnati Eye Institute.

MARVIN RORICK, MD, Cincinnati, became the 142nd president of the Academy of Medicine of Cincinnati. A neurologist with Riverhills Healthcare, Inc., a group of 17 neurologists and six neurosurgeons. One area Dr. Rorick plans to address is managed-care contracting. He wants to help physicians understand the contracts they're signing so that they know when to sign and when to be wary.

Dr. Hussain charts origins of Indus River

Growing up in Northern Pakistan, OSMA member Sayed Hussain, MD, says his childhood was greatly influenced by the Indus River. He hunted and fished with his brothers on the Kabul River, a major tributary of the Indus. He listened to stories of his ancestors who farmed along its banks, and of his grandfather, who, as a country doctor in the 1870s, frequently traveled by riverboat. Dr. Hussain's childhood fascination with the Indus River would eventually become an adult obsession.

Known as the "Father of the Rivers" in Pakistan, the Indus River, according to Tibetan folklore, arises from the mouth of a lion along the slopes of Mount Kailash in southwestern Tibet. Flowing west through India and Pakistan, it ends its 2,400 mile journey at the Arabian Sea. It is this

route that Dr. Hussain and fellow explorers, known as Team Indus, would cover.

"It is my personal ambition to photograph and study the river and its people," explains Dr. Hussain. "There is also a great sense of adventure in this trek," he adds. The headwaters of the Indus have been seen by only two previous Westerners. Swedish explorer Sven Hedin in 1907 and American backpacker, John Bellezza in 1982. In three separate expeditions, from 1987 to 1990, Team Indus covered 2,000 miles of the river in Pakistan. The goal of their fourth trip was to reach Senge Kabob - the "Mouth of the Lion" in Tibet.

Accompanied by four Sherpas, a guide, 19 yaks and provisions for a month, Team Indus left Kathmandu on July 20, 1996. Existing on a diet of

rice, lentil soup and bread, Dr. Hussain's team crossed the harsh landscape of the Tibet Plateau, battling high altitude sickness, physical exhaustion and a snow and hail storm at 18,500 feet. "Our main purpose is to pit ourselves against the elements as well as to study and document a 5,000 year old civilization," states Dr. Hussain. Carrying twice the annual flow of the Nile River, the Indus River once cradled an advanced civilization. Over the past 5,000 years, the Indus Valley has been home to Hindu kings, Buddhist monks, Arabs, Asian Mongols and the British.

Upon reaching Senge Kabob, the team found the site marked with prayer flags as is Tibetan tradition for holy places. The Indus arises as a spring at the base of a small hill - "from the lap of the earth" as Sven

Hedin described it in 1907. "It is hard to believe," muses Dr. Hussain, "that the Father of the Rivers has such a humble birthplace, a tiny spring 17,000 feet high on the Tibetan Plateau." Yet great things start with small beginnings, be it a raging river or an expedition born of a childhood dream.

In a world where geopolitical borders are greater barriers than natural obstacles, Dr. Hussain's present dream is to, one day, float down the Indus, through Chinese-controlled Tibet, without the threat of soldiers turning guns on him.

Dr. Sayed Hussain's travels are documented in his recently published book, *Of Home & Country - Journey of a Native Son*. - Pam Willis

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OSMA, Cleveland Academy of Medicine mediate dispute

Efforts made to resolve litigation following Academy of Medicine of Cleveland's charter revocation.

By the time you read this article, a decision will already have been made regarding whether a last attempt at mediation will forestall a lawsuit that may sever all ties between the OSMA and the Academy of Medicine of Cleveland (AMC). The outcome of the mediation is expected by Dec. 3 and will be posted on the OSMA Web site at www.osma.org.

On Dec. 2 representatives of the OSMA and the AMC met with an independent mediator in a final bid to re-

solve continuing difficulties caused by the fact that the AMC violated its charter held by the OSMA. Under the "unified membership" provisions of the state/county charter agreement which was implemented in 1848, neither the county society nor the OSMA may accept physicians as members who don't join the other society.

Several efforts have been made in the past to alter the unified membership provision. As recently as May 1998, the OSMA House of Delegates affirmed the existing policy that the county/state membership link is impor-

tant and should be kept intact.

Despite that decision, in July 1998, AMC approached the OSMA Council with a proposal to allow Cuyahoga County physicians to join the academy without joining the OSMA. The Council, citing the recent House of Delegates decision, turned down that proposal.

On Sept. 21, 1998, the AMC took action without notifying the OSMA or without its approval. The AMC mailed its 1999 membership solicitation inviting county physicians to join AMC

continued on page 3

Aetna makes few contract concessions

A meeting between OSMA and officials of Aetna Insurance Company over physician contract terms was cordial but didn't accomplish what the OSMA had hoped.

"The primary concerns of our members weren't resolved," says Katrina English, JD, director of OSMA's Division of Legal Affairs.

Members have actively voiced their dislike over language that requires them to participate in all Aetna products, including its HMO. Primary care doctors are especially concerned about being forced to accept capitation, a di-



Pain management was the topic of a live presentation on the OMEN/OMEN-TV Network in October. Jim Allen, MD, OMEN moderator, (left) fielded questions from viewers to panel members Costantino Benedetti, MD, (center), and Mark Boswell, MD, PhD. The program, "Management of Chronic Pain" was broadcast live to 70 hospitals and 75 other locations across the Central and Eastern time zones. Next month, *Ohio Medicine* will bring you more on the pain initiative.

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without joining the OSMA, AMC, whose membership has declined dramatically over the past 10 years, has steadfastly maintained that the reason for its declining membership is the cost involved when local physicians wishing to join AMC must also join the OSMA. A survey conducted jointly by the OSMA and AMC in 1997 revealed that cost was only one of the several reasons for declining membership in AMC/OSMA.

In October, the Council authorized OSMA President Lance Talmage, MD, to meet with AMC leadership to suggest that the situation could be resolved if AMC would either voluntarily surrender its charter or delay action and bring the issue to the 1999 OSMA House of Delegates. By voluntarily surrendering its charter, AMC would be able to offer county-only membership legitimately. In turn, the OSMA would then be able to directly market to Cuyahoga County physicians through a new component society established in Cuyahoga County.

continued from page 1

AMC rejected this proposal. At that point, the OSMA Council felt it had no choice but to revoke the AMC charter and it did so on Nov. 10. Council later acted to charter a new county society, the Cuyahoga County Medical Society (CCMS). On Nov. 16, AMC filed a lawsuit asking a court in Cuyahoga County to stop the OSMA from revoking its charter and from chartering a new society.

If the current mediation effort is successful, the OSMA and AMC will have agreed to a plan that addresses the AMC's violation of the OSMA's by-laws. If the mediation fails, the OSMA will activate the already-approved creation of the CCMS and mail pertinent membership information, along with a dues statement, to Cuyahoga County physicians. AMC will no longer be linked to the OSMA and will no longer serve as the approved structure for Cuyahoga County physicians to participate in OSMA's statewide initiatives and policy-making. ■

Chronic pain handbook to be mailed in January

Pain – The Fifth Vital Sign, the pain management handbook developed by the OSMA's Ad Hoc Committee on Pain Education, is due to be mailed in January.

The handbook will be distributed to all Ohio physicians, as mandated by Senate Bill 187 (SB 187), the pain control legislation. The OSMA agreed to develop and mail the handbook not only because of the importance of the issue but also because, in return, the Legislature agreed to drop language from the bill that would have required all Ohio physicians to obtain two hours of CME credit on pain management.

The handbook will offer two hours of Category I CME. The printing and mailing of the handbook was supported by an unrestricted educational grant from the Roxane Institute.

The pain control legislation also re-

quired the State Medical Board of Ohio to adopt rules establishing standards and procedures for physicians in the diagnosis and treatment of intractable pain, including standards for managing this type of pain by prescribing, dispensing, or administering dangerous drugs in amounts that may not be appropriate when treating other medical conditions.

A checklist included with the handbook was developed to assist physicians in compliance with the rules.

Those rules became effective Nov. 11 and can be found on the OSMA Web site at www.osma.org. ■

Aetna...

continued from page 1

rect result of having to participate in the HMO product.

Although both of these concerns were raised with Aetna, "The bottom line is, they intend to enforce the all-or-nothing provision in provider contracts," says Bill Fry, director of Om-budsman Services who also attended the meeting.

Aetna was willing to make some concessions, says English, but only minor ones. "Aetna has attempted to resolve tensions by making its new contracts appear more physician-friendly."

The carrier's new contracts, for example, will be written in clearer lan-

guage (less legalese), and will include:

- Additional language that encourages physicians to advocate on behalf of or provide information and assistance to their patients;

- A statement that physicians make all medical decisions for their patients, while the health plan's role is to make coverage determinations; and

- A provision that the confidentiality of member records will be safeguarded by both physicians and the plan.

Aetna will introduce its new contracts first in Ohio, Texas and Florida. ■

Annual Meeting in Cincinnati

The 1999 OSMA Annual Meeting will be held May 15-16 in Cincinnati at the Hyatt Regency Cincinnati.

Resolution deadline is 5 p.m. **March 15**. Resolutions must be mailed to the Executive Director, Brent Mulgrew, Ohio State Medical Association, 3401 Mill Run Drive, Hilliard, OH 43026. For more information contact Susie Paulus, (800) 766-6762, Ext. 6727. ■

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Bills, Laws & Rules

Michigan defeats assisted suicide proposal

One of the more interesting issues to go to the voters during last month's election, was the assisted suicide proposal that Ohio's northern neighbor, Michigan, was forced to wrestle with at the polls. With Jack Kevorkian, MD, actively practicing his own brand of mercy killings in that state, the fact that the issue surfaced there is not surprising. Yet no one was sure of the outcome. A mid-October poll indicated that more than half of the state's voters favored Proposal B (as the issue was known), but in the final weeks before the Nov. 3 election, public support declined.

Ultimately, Michigan voters defeated by nearly three to one the ballot issue that would have made their state the second in the nation to legalize physician-assisted suicide (Oregon is presently the only state with such a law on its books). Cathy O. Blight, MD, president of the Michigan State Medical Society (MSMS) believes the proposal was brought down by a grassroots effort to educate the public. MSMS was among a number of groups that formed Citizens for Compassionate Care. The coalition, Dr. Blight says, "spent a good deal of time educating their members and their constituents, and then those people went out and educated the general public on what Proposal B really said and really meant."

MSMS policy (like OSMA and AMA policy, see related story) opposes physician-assisted suicide, though that position is by no means unanimous. "We understand there are physicians who believe in physician-assisted suicide," Dr. Blight says. "We hear them at meetings. There's an ongoing debate about whether it should be legal or shouldn't, and a physician's role. We

also know we have a fair number of members who want it outlawed."

Administrative nightmare

The society's objection to Proposal B stemmed not from the controversy, however, but from the administrative nightmare it would have created. "Among various problems," Dr. Blight wrote in a *Grassroots Alert* in September, "the proposal would create an end-of-life bureaucracy that could discourage physicians from providing effective palliative care to their terminally ill patients who are not seeking assisted suicide." Michigan law already provided immunity from liability, both administrative and civil, for a physician who, in good faith, prescribed controlled substances for treatment of a patient with a terminal illness or to ease a patient's pain, even if taking the medication shortened the patient's life. Under Proposal B, if a physician had prescribed medication that was determined later, by a third party or jury, to be intended to hasten death, that physician could be guilty of a felony.

Proposal B would have required that a physician, not willing to carry out an assisted suicide within the dictates of the law, find the patient another physician who would be willing. If a referral wasn't made within 72 hours, the referring physician could be prosecuted.

Voluminous record keeping

The proposal also would have required the attending physician to document in the patient's medical record such information as the patient's competency in making a voluntary, informed request for assisted suicide, each oral and written request by the patient, the attending physician's diag-

nosis of terminal illness, and the prognosis. Other required documentation would have included the consulting physician's confirmation of the diagnosis, prognosis, competency, and understanding of the patient, a written statement from a psychiatrist, notice of the attending physician's offer to the patient to rescind the request for assisted suicide, and if the patient chose to continue, the steps taken to carry out the request. The law would have required the attending physician to keep those records for at least three years. "No other law dictates such specific, voluminous record keeping," MSMS legal counsel Richard D. Weber wrote in the *Grassroots Alert*. "No other law mandates that physicians keep records for a specific period of time with criminal sanctions imposed for violation."

The law would have based immunity for assisting in a suicide on adherence to applicable standards of practice. "Is there a standard of practice for physicians in assisting a person to commit suicide?" Weber wrote. "If not, immunity is illusory."

Citizens for Compassionate Care must remain active regardless of Proposal B's resounding defeat, Dr. Blight says. "Some members of the coalition believe the issue will disappear. I don't think that's the case. What the medical society needs to do is continue its educational efforts in terms of hospice and palliative care, and heighten the work of people involved in those areas. We see it as a challenge to make sure that the citizens of Michigan understand there are other options at the end of life. Hopefully, they will not have to resort to physician-assisted suicide or be concerned about that being an option for them." — Jan Leibovitz Alloy

AMA, OSMA oppose assisted suicide

The American Medical Association holds that if a patient's preferences go against a physician's commitment to sustain life and relieve suffering, the patient's wishes should hold more weight — if a mentally competent patient refuses life-sustaining treatment, the physician must comply. The physician also is obliged to relieve the patient's suffering, including prescribing effective palliative treatment, even if that treatment will hasten the patient's death.

Although the AMA prohibits assisted suicide, Section H-140.966 of the AMA Current Ethical Opinions & House of Delegates Policies states "Physicians must not perform euthanasia or participate in assisted suicide." While admitting the need to study the issue further, the policy says "the risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time."

The OSMA is active in its opposition to assisted suicide, says Legal Affairs Director Katrina English, JD. "We have a House of Delegates policy that says the association is against euthanasia and a later policy that the organization is officially opposed to physician-assisted suicide. If legislation permitting physician-assisted suicide would be proposed, we would oppose it."

In fact, the issue did come up in Ohio, says Marla Eshelman Bump, OSMA associate director of legislation, but it went nowhere. Had Proposal B passed, Michigan's proximity might or might not have prompted another look. "There's not been a lot going on in the state of Ohio on this issue," Bump says.

Ohio currently has no suicide statute, English says. But a physician who assisted at a suicide could be prosecuted for manslaughter or murder. — Jan Leibovitz Alloy

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Quick news

Calling all potential candidates...The AMPAC Campaign School is now accepting applications for its 1999 class. The school, a program of the American Medical Political Action Committee, is bipartisan and is designed to give participants the tools they need to run a successful campaign, and to be a voice for organized medicine. The school will be held Wednesday, Feb. 3 through Saturday, Feb. 7, 1999 at the Ritz-Carlton Hotel in Arlington, Virginia, just outside of Washington D.C. Enrollment is open to AMA members and spouses. The registration fee is waived and airfare is provided unless the participant is a candidate for federal office, in which case special rules apply. Non-AMA members may apply but there is a \$1,000 registration fee and airfare is not provided. If you are interested in applying, contact Krista Bistline, OSMA Department of Legislation (800) 766-6762, Ext. 6748, e-mail: bistline@osma.org.

Bill addresses noncomplete clauses...Sen. Robert A. Gardner (R-Madison) has introduced Senate Bill 280 which states a physician who leaves a group practice (after the act's effective date) can't be prohibited by terms of any document from contracting and continuing to provide health-care services to persons who were the physician's patients in the practice.

Hearing Dec. 10 on standardized credentialing form...The creation of a standardized credentialing form is one step closer to completion. The Ohio Department of Insurance has drafted a standardized credentialing form as required by the Physician-Health Plan Partnership Act, and has filed it with the rules-reviewing agency of the state government. Although the process toward implementing a standard credentialing form has begun, it still has a way to go. A public hearing on the form is scheduled for Dec. 10 at 10 a.m. at the Ohio Department of Insurance (Columbus), and comments from these hearings will be taken under advisement before a final form is submitted. If you'd like a copy of the rule, contact the OSMA Division of Legal Affairs at (800) 766-6762, Ext. 6769. According to the new law, health insuring corporations (HICs) will have up to 120 days to begin using the new form, once it has been finalized. In the meantime, physicians should continue to complete those forms that have been given to them by HICs.

Election gives GOP big wins...Republicans swept all top state offices, including the governor's post, in November. Bob Taft, Ohio's new governor, was endorsed by the Ohio Medical Political Action Committee. Former Gov. George V. Voinovich is the state's new U.S. senator. Ohio's congressional delegation remains the same, with all incumbents winning their races. The Republicans maintain their majority. In the Ohio House, Republicans have also held on to their 59-40 majority. Rep. John Garcia (R-Toledo), of the 50th House District, will be replaced by Democrat Jeanine Perry. There were several close races on election day, and there was discussion of a recount in the 18th, 57th, and 63rd House Districts, but the GOP majority remains intact. Republicans also held on to their 21-12 majority in the Ohio Senate. However, there will be changes in two Senate seats. In the 9th Senate District, incumbent Republican Janet Howard lost to Rep. Mark Mallory (D-Cincinnati) and Jeffrey Armbruster (R-North Ridgeville) defeated former Democratic Sen. Ronald Nabakowski of Amherst by 600 votes in the 13th Senate District. The 13th Senate District was an open seat due to the retirement of Sen. Alan Zaleski (D-Vermilion). In the important Ohio Supreme Court races, Chief Justice Thomas Moyer easily won his race against challenger G. Gary Tyack while Justices Francis Sweeney and Paul Pfeifer defeated their respective opponents, Stephen Powell and Ron Suster. The court remains Republican 5-2.

OAFP position on APN prescribing not final...Ann Spicer, executive director of the Ohio Academy of Family Physicians, reports that the OAFP has not made any final decision about a position on APN prescribing. ■

Specific CME now required in Florida

If you hold licensure in the state of Florida or plan to – even though you don't currently reside or practice in the state – you must now complete specific medical education requirements in order to earn initial licensure or to renew your medical license.

The Florida Legislature has mandated first-time licensees to complete three hours of AMA Category 1 CME in HIV/AIDS and one hour of domestic violence education. For first-time license renewals, physicians must complete one hour each in risk management, HIV/AIDS and domestic violence. For continuing license renewal, Florida requires a total of 40 hours of AMA Category 1 CME, in-

cluding one hour each in HIV/AIDS and domestic violence. The current biennium extends from Feb. 1, 1998-Jan. 31, 2000. ■

Take Action

The Florida Medical Association (FMA) has developed one and three-hour long study courses in HIV/AIDS as well as a one-hour home study course in domestic violence and risk management. If you would like more information, or to order courses, contact the FMA Education Department at (850) 224-6496; fax (850) 222-8030 or e-mail: education@mdaone.org.

Educate your patients on their right to appeal

Are your patients aware of their new right to appeal health-care decisions made by their plans?

In response to member suggestions, the OSMA has developed a handout for physician offices that can be used to educate your patients about their appeal rights under the Physician-Health Plan Partnership Act (PHPPA). Ohio's new managed-care reform law developed by the OSMA and Kaiser Permanente. The handout, which will be provided to members upon request, explains how patients may appeal plan decisions.

Late this fall, the OSMA mailed to all members information about the new law, which became effective Oct. 1. That packet included tent cards for physician offices, a handout for patients explaining how they are affected by the law, plus two brochures for physicians.

One brochure explained physician appeal rights and the other was a contract checklist. Both the original handout for patients, and the one just developed, are designed to be photocopied by physician office staff for distribu-



If your patients are not aware of their right to appeal health-care decisions, the OSMA has materials that can help.

tion to patients. ■

Take Action

If you would like a copy of the new patient handout describing their appeal rights under the PHPPA, contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #38-98.

Indepth Report

Dealing with the media

When she started running media workshops 20 years ago, Rebecca J. Doll, then associate director of OSMA, often met resistance from physicians critical of the media. "They would say things like, 'If we don't participate with them, they won't have anything to write about. So we'll just stonewall them.'"

Bad attitude, says Doll, now vice president of Market Group One in Columbus. If an ophthalmologist won't talk, perhaps an optometrist will. If there's no ob-gyn available for comment, a reporter may look for a midwife. "The news will go with or without you," Doll says. "You have to decide if you're going to be the credible voice or if you're going to let somebody else do it."

Talking to the media can be a daunting experience. Here are some tips to make it less so:

• Prepare for the interview.

"When you get a call from a reporter," says Carol Mullinax, director of OSMA Division of Public Affairs, "find out why they're calling. And also find out what the reporter's deadline is. Then hang up and take a few minutes to think about what you want to say. Thinking it through can prevent misstatements." Most reporters are understanding of your need to collect your thoughts. They want your information to be accurate.

jot down notes about your subject, Doll adds, "even if you think you know it inside and outside and upside." Even the most proficient public speaker can get distracted. "We've got a really good tape where we show Secretary of State Baker making a big speech, and he totally forgets a major point."

• If you make a mistake, say so. "It's to the reporter's interest that you sound knowledgeable and informed," Mullinax says. "If you feel that you



The news will go with or without you. You have to decide if you're going to be the credible voice or if you're going to let someone else do it.

didn't say it the best way you could, say, 'Can I please say it again?' If it's a live (broadcast) interview, you can say, 'In other words, what I'm saying is ...' or, 'Let me clarify this. What I mean to say is ...' As you hear it come out of your mouth, if it doesn't sound right, you need to correct it."

Still, you could be misquoted, says Linda Siefkas, vice president and manager of the Columbus office of Edward Howard & Co., a public relations firm. If your story runs with a factual error, let the reporter know. Down the line, another reporter might search the databank for stories on that topic; without a correction, the error could be perpetuated.

But don't sweat the small stuff with reporters. "They're the ones who buy ink by the barrel," Siefkas says. "It's not a good idea to end up in a contest over a minor misquote."

• Make yourself available for further clarification. You can't see the story in advance, but you can offer further assistance, Mullinax says. "You can say, 'I know that last part is difficult—is there any part of what I said that you want to read back to me?'" Try to provide the reporter with a handout that illustrates your point.

And give him or her your home phone number in case questions come up.

• Never say, "No comment." If you'd rather not talk, Doll says, give a reason: "Until we know for sure what's going on, it wouldn't be proper for me to comment." "I'm sure if it were you, you'd understand that the patient has the right to privacy." "I'm not the person to comment on that. Someone else is better informed than I am. Let me get that name to you."

If you're involved in litigation, Siefkas says, "You can still comment and get your message out without making any comment on the specific litigation: 'It may be interesting to note, in my 30 years of practice, I have never (before) had a lawsuit of this nature filed.'"

• Use laymen's language. Most people don't understand the acronyms and technical terms you use as a matter of course. Don't assume a reporter will, either. Speaking in jargon is the easiest way to get misquoted, Doll says.

• Discuss how a situation affects patients, not how it affects you. Humanize the story with anecdotes from

continued on page 8

Everything you say to reporter is on the record


Never say anything you would not want to see on a billboard the next day. From the moment a reporter steps into the room until the moment the reporter leaves, everything you say is on the record. "Off the record" is a game that plays better on TV than in real life, says Carol Mullinax, director, OSMA Division of Public Affairs. She cites the case of a physician in a small town who made a supposedly off-the-record comment to a reporter. The reporter referred to the statement without attribution, but the doctor caught heat for it anyway. The town was small enough that everyone could figure out who was talking.

And don't expect to get buddy-buddy with a reporter to alter the billboard rule. Like you, a reporter has a mission and will do the best he or she can do to fulfill that mission, regardless of your friendship. "Forget 'fair,'" Doll says. "Don't expect it to be. They own the antenna, it's a business and there's bias."

Even so, it's a good idea to develop relationships with the media when things are going well for you. Help reporters think of you as a possible source when they need quotes from an expert. And help them understand your integrity in case they come to you because something has gone wrong.

No matter how media savvy you believe you are, it never hurts to take the workshops offered by hospitals and associations. If you've been contacted for an interview and want to discuss the specifics, call the OSMA.

Keep in mind, Doll says, "You are the expert. You have message content. What you need is the delivery technique. You have to learn the rules—it's like any other game—and use the rules to your advantage." — Jan Leibovitz, Alloy



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Media...

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real life. If possible, suggest a patient, after receiving his or her permission, that the reporter might interview, Siefkas says. "Most TV reporters don't want a talking-head doctor."

- **Show you care.** "Because of their professional demeanor, physicians often come across as insensitive when the opposite is true," Siefkas says. She recalls a media training during which she asked a group of physicians to describe their work. Every one answered in terms of body parts. "They had a very difficult time using 'I' words and saying care. If you saw that on TV, you'd think, 'aren't they snobbish' – I wouldn't want to go to them. They're so concerned about being accurate and professional that they sometimes come across as being rigid."

- **Take it easy.** Being interviewed can feel intimidating; good preparation will give you confidence. "One of the things you do day in and day out is explain things to people," Mullinax says. "One of the things you're going to be called on to do in this interview is to explain things to a larger group of people. Pull on those same skills."

- **Know the point you want to make and work it into the conversation.** Say you treated a patient who subsequently dies in transit to another hospital, and a reporter asks what you did that made you want to wash your hands of that patient. "They're trying to ask a question that makes it an interesting story, that sets up conflict or something sensational," Siefkas says. "They want to get you riled up. One way to answer that is, 'Well, let me tell you our policies on transferring patients.' It may not answer that question directly, but most of the time the reporter's thinking of the next question to ask, and they're not listening anyway."

Although the interview may last a half hour, the reporter will likely distill your message into a single printed quote or, for broadcast, a 20-second clip, says Doll. Before the interview, decide on your single overriding communications objective – your "SOCO statement and make it work." – Jan Leibovitz Alloy

OSMA News



The CME dilemma:

Have to have it, where shall I get it?

Thanks to the OSMA Committee on Education, earning CME credit in Ohio is easier and more convenient than you might think.

CME. One of medicine's "little essentials." The state requires it...your own professionalism demands it...but how do you find time to earn it?

That's where the OSMA steps in. The association's Committee on Education makes earning CME credit much easier – if you're aware of the services it offers you.

The trouble is – most members don't know about these services. According to a survey on the subject, conducted recently by the OSMA, most members are unaware of what the OSMA can do to make earning CME easier for you.

For example, did you know that the OSMA:

Can help you turn your medical staff meeting or county medical society function into a CME opportunity?

The Committee on Education is available to assist you with any educational meetings you may be planning – and make them available for Category 1 credit.

Can help your local hospital become a CME sponsor?

If you wish your local hospital's educational programs were available for CME credit, the OSMA can turn that wish into a reality by accrediting the hospital as a CME sponsor. The OSMA is the state's official accrediting

body. While accreditation is actually the function of the association's Committee on Accreditation, the Committee on Education can assist that process by mentoring the hospital that would like to take this step. Think how much easier it would be to earn CME so close to home – at a noon seminar, for instance. And how much more pertinent it would be if it dealt with a subject unique to your area's needs. Currently, there are about 70 accredited sponsoring organizations in Ohio. Almost all of them are hospitals. Your hospital could be added to that list.

Can help you earn CME at home?

The Committee on Education works with OSMA staff, Council, and other committees to generate material on important topics that can be read at home at your convenience. After reviewing the material, you take a self-administered test and, depending on the results, you earn CME credit hours – without having to travel or go to the expense of attending a conference or seminar. To illustrate: Early next year, you will receive a handbook, entitled *Pain – The Fifth Vital Sign*, on managing chronic pain, developed by the Committee on Education and an ad hoc committee of pain specialists. The Committee on Education developed the handbook for CME credit, just as it has done on previous occasions with Domestic Violence handbooks and other material. Look for the Committee on Education to generate more such informational material in 1999. An update on the domestic violence handbooks is already under way, and a publication on osteoporosis is being planned.

Can help you find CME opportunities around the state?

If you have visited the OSMA Web site, www.osma.org, then you're already familiar with the navigational feature that will take you directly to current and future CME opportunities. You can call up these educational programs by location, date, or topic of interest. The OSMA also publishes an "Opportunities Listing" – a calendar of scheduled CME events that is distributed in six-month intervals. See "Take Action" for more information.

Can help you earn your CME and have some fun too?

OK. According to the survey, most members list convenience as a major consideration in earning their CME. But there is a benefit to sometimes having a little fun while earning your credit. That's why the OSMA is collaborating with the West Virginia State Medical Association (WVSMA) to hold a regional conference in the summer of 2000 at the Greenbrier Resort in White Sulphur Springs, West Virginia. Nancy Albright, associate executive director of the WVSMA is enthusiastic about the prospect: "We plan to have presentations on a variety of 'hot' topics that affect medical practice today," says Albright. "There will be 'Lunch and Learn' sessions, where discussions will be led by state medical association presidents, and even the president of the AMA."

The Committee on Education, chaired by W. David Dawdy, MD, Columbus, is serious about making CME accessible to you – and in the

CME survey results show managed care is hot topic

This summer, the OSMA Committee on Education sent a questionnaire to the association's survey group of 400 randomly-selected members to help it determine physician educational needs. Among other discoveries, the survey showed that a number of respondents obtained their continuing medical education from printed media (22%), although live presentations still ranked number one (66%), and audiocassettes are becoming more popular (11%).

Survey respondents indicated that the primary determinant in choosing CME activities is the subject/speaker (34%), followed closely by time/availability (30%), location (18%) and hours of credit (10%).

When asked what topics should be covered in future CME presentations, the 400 respondents indicated that more information is needed on such subjects as: managed care, medical ethics, end-of-life issues, outcomes studies, risk management, capitation, documentation, transplantation, office management, AIDS, tuberculosis, and coding.

The OSMA Committee on Education continues to survey members on the subject of their CME needs, and will take these responses under consideration as it plans and designs CME programs for next year and on into the future.

If you wish to make suggestions to the committee regarding a CME topic, or the form you prefer to receive your CME, you may do so by contacting Janet Shaw, director, OSMA Department of Continuing Education and Outcomes Research, (800) 766-6762, Ext. 6737, e-mail: cme-outcomes@osma.org. ■

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CME...

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most usable form. How?

Consider this:

- When the OSMA learns of a CME offering in northern Ohio, and is aware of a need for a similar program in southern Ohio, the association can be instrumental in taking that program on the road, so it can be available in other parts of the state.

- When an out-of-state group wishes to offer CME opportunities in Ohio, the committee can step in to make sure its program is tailored to meet Ohio-specific guidelines and requirements for CME.

As if all this isn't enough, the committee has ambitions to expand its role. Next year, its focus will be on these areas:

- Generating more enduring educational material (handbooks, publications, etc.). (See related story.)
- Measuring CME's impact. Look for the committee to send you follow-up questionnaires on some of the CME activities you attend. Their intent: To see if the information you learned in the CME activity caused you to change the way you practice.
- Educating the educators. The committee will look for the best CME educators and use their successful techniques to help other educators improve their CME courses.

Beginning in January, *Ohio Medicine* will highlight special CME courses, activities, and other topics related to continuing medical education.

Thanks to the OSMA and the efforts of its Committee on Education, earning CME in Ohio doesn't have to be a dilemma at all. — *Yvonne Burry*

Take Action

For a copy of the recent "Opportunities Listing", contact the *Ohio Medicine* reader response line, (800) 766-6762, Ext. 6580, and ask for Item #39-98. For a subscription, call (800) 766-6762, Ext. 6735. To learn how the OSMA can assist you with your educational needs, contact Janet Show, director, Department of Continuing Education and Outcomes Research, (800) 766-6762, Ext. 6737.

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AMA report

Danger in the workplace: "This isn't about abortion, it's about violence"

By Andrew Thomas, MD

On Oct. 23, Dr. Barnett Slepian, an obstetrician-gynecologist who performed abortions as a routine part of his medical practice, was fatally shot in his home in Buffalo, New York. As of the time of this writing, authorities are searching for a man wanted as a material witness, but no suspect has been arrested. While law enforcement officials from the United States and Canada cooperate to find the killer, organized medicine has been working to accomplish two specific goals: to work with law enforcement officials to ensure that this tragedy is not repeated, and to better expose the issue of workplace violence against physicians and other health-care workers.

Dr. Slepian's name was found on a Web site with other "targeted" individuals who included "alleged abortionists and their accomplices, clinic owners and workers, judges, politicians, law enforcement officials and spouses." Although many were not involved in performing abortions, approximately 225 doctors were listed on the Web site as either "working," "wounded," or "fatality." In fact, soon after the killing, Dr. Slepian's name was overstruck on the list. In the case of the physicians listed, the Web site further recommended the AMA's Physician Select Internet site as an efficient way to get information on and to locate the targeted individuals.

A specially-trained 20-member team of AMA staff worked to warn all of the physicians listed. They were also given contact numbers of their local U.S. Marshall's office if they desired a personal security assessment and given the option of having their names and information taken off the AMA Web site.



Andrew Thomas, MD

Comments from the targeted physicians were also forwarded to federal law enforcement officials during an unprecedented meeting that was featured on the front page of *USA Today*. AMA Board of Trustees Vice Chair Ted Lewers, MD, and senior AMA staff met with the Deputy Attorney General, the Deputy Director of the FBI, and 16 other federal officials on Nov. 2 to discuss the issue of violence and terrorist activity against physicians and other health-care workers. Also included in the meeting were senior representatives from the American College of Obstetricians-Gynecologists, the American Academy of Family Physicians, the American Psychiatric Association, the American College of Emergency Physicians and the Medical Society of the State of New York. On Nov. 5, as a direct result of the AMA's advocacy efforts, the Justice Department named a special task force on anti-abortion violence, specifically looking for evidence of a wide conspiracy of terror directed at physicians and health-care workers.

"This is not about abortion; this is about violence. Physicians and health-care workers face a serious risk of work-related violence, and the problem is getting worse," says Dr. Lewers. Among other suggestions was an 800 number for physicians to call if they feel threatened and a plea from the Justice Department for state and county medical societies to hold meetings with local law enforcement officials and to use the U.S. Marshall's security guidelines as a model for their discussions.

Most physicians are already aware of the Slepian tragedy. However, the threat of violence or terrorist acts directed at doctors and other health-care workers is an issue far beyond a single politically motivated act in upstate New York. As noted above, reinforcing the importance of this general issue to physicians and their families is an important part of the AMA's action plan.

Workplace violence high

The U.S. Bureau of Labor Statistics reports that health-care workers have a 16-fold increased risk of violence against them in the workplace, compared to other workers. A separate, recent survey of 475 resident physicians in 57 different residency programs found that 38% had been a victim of physical abuse with 20% reporting multiple instances of violence. Of respondents from emergency medicine, 72% reported an attack on ER staff within the last five years.

Whether threatened by co-workers, patients or patient's families, physicians need to be on guard for behaviors related to workplace violence. These include harassment, stalking, inappropriate communication, including e-mail and phone calls, intimidation

and verbal threats. The AMA is developing a list of "best practices" for physician protection which will be placed on the AMA's Web site. We are also cooperating with the American Hospital Association and the International Association for Healthcare Security and Safety. The AMA's Commissioners on the JACHO will also take our message to that organization to advocate for stronger security standards to protect all health-care professionals. ■

Take Action

If you, or a family member feels threatened, contact either the OSMa at (800) 766-6762 or the AMA at (800) 262-3211. You can keep updated by visiting the AMA's Web site at www.ama-assn.org.

AMA continues to protect physicians' rights

The American Medical Association's activities to prevent violence in the workplace is part of an ongoing effort to protect physicians' rights to practice high-quality medicine on behalf of their patients. Previously, the AMA has taken action on behalf of biomedical researchers, targeted by an extreme faction of "animal rights activists," as well as workers at risk in hospitals, especially emergency departments.

Among the first steps the AMA plans to take will be to help physicians access useful, educational information on violence prevention in the medical workplace.

In 1994, the AMA Young Physicians Section published a report entitled "Violence in the Medical Work-

place: Prevention Strategies." This comprehensive report sought to expose the broad spectrum of violence potential which can threaten medical work environments. Included in the report were suggested violence prevention measures which included knowing and recognizing possible predictable clues to violent behavior, how to incorporate personal precautions, and how to secure safety through a protected physical environment.

Another recommendation is to contact local law enforcement agencies to become aware of what protective services are available and how to appropriately respond in the event of a perceived threat of violence.

The AMA considers potential for violence in the medical workplace to be a serious matter. I would be interested in hearing from any readers who have further comment on this subject. — *Herman I. Abramowitz, MD*, Dayton, AMA Board of Trustees.



Herman I. Abramowitz, MD

Welcome to the real world of medicine...

Each December, *Ohio Medicine* and the Ohio State Medical Association recognize those physicians, under age 40 or who have been in practice five years or less, who have demonstrated the best qualities of the profession. The four individuals selected for this honor this year are outstanding examples of all that is best in medicine. They are achievers who embody the profession's highest ideals. Not only have they conscientiously delivered the highest quality care to their patients, they have also contributed outside their practices to the community at large. This year, we asked our honorees for advice they might pass on to a new young physician, someone who may be entering practice for the first time. Here are their responses.

What advice would you give a new "young physician," about to enter practice?

"Medicine is without question the most exciting and dynamic profession in which to practice. The honor to serve your patients complements the ever continuing opportunity to expand one's knowledge. Perceived obstacles can turn into rich opportunities for the physician who can balance patient care needs with the ever-changing medical climate. The future of medicine in every field remains brighter than ever with expanded opportunities to communicate and work with physician colleagues, administrators and other business executives. Organized medicine will continue to help us maintain our professional excellence while we negotiate through uncharted territory."
— **Stephen M. Boorstein, MD**

"My best advice to any physician, young or old, is to practice medicine to the best of your ability and treat all patients as you would your parents, spouse or children. Medicine is an ever-changing field that sometimes seems to have become as much a business as an art, but we must never allow the integrity of the one-on-one patient encounter to ever be overshadowed by managed care, reimbursement, malpractice and the other external factors involved in the delivery of care. I was

once taught and completely agree that we should always thank our patients for entrusting their lives to us. Saying "thank you" is easy to do, but I imagine something rarely practiced by many of us. Although being involved in the many aspects of medicine has been very educational and interesting and something that all of us could or even should do, the one thing we MUST do is to treat every patient as we would want to be treated ourselves. If you practice quality care in a caring manner, all else will take care of itself."
— **David C. Packo, MD, FACEP**

"In these early years of private practice, I have collected a group of phrases that summarize my philosophy. This is my advice to a physician who is about to embark on the greatest voyage of his/her life — the practice of medicine.

Medicine's Little Instruction List

- Take care of sick folks.*
- Treat patients as friends — with courtesy, respect, fairness, and as human beings.*
- Be honest. Admit when a mistake has been made.*
- Ask for help when you are in trouble.*
- If another physician asks for help, give it without hesitation.*
- Never turn away a patient who requests your services.*
- Do the right thing, regardless of what others think.*
- A satisfied patient is your best source of referrals. A happy staff is your second best source.*
- Hold yourself to the highest standards.*
- Don't cut corners.*
- Don't be greedy.*
- Open your arms to change, but don't let go of your values.*
- When negotiating, if you don't get it in writing, you probably won't get it.*
- Pass along your knowledge to someone junior in your field.*
- Be passionate about your field and apply it to patient care.*
- Remember to give your family attention.*
- Read "Life's Little Instruction Book" by H. Jackson Brown, Jr. — Piyush N. Sheth, MD*

continued on page 15

Piyush N. Sheth, MD

Graduated from: Loyola University of Chicago, Stritch School of Medicine, 1990

Practice location: Ashland

Specialty: General surgery, solo practice, board-certified

Achievements: Faculty Award for Excellence in the Basic Sciences; Resident Achievement Award, Society of Laparoscopic Surgeons; AMA Physician Recognition Award.



Piyush N. Sheth, MD

First: First surgeon in Ashland to perform advanced laparoscopic surgery.

Memberships: American College of Surgeons; Society of Laparoscopic Surgeons; OSMA; AMA.

Activities: Author of the *Gen/Surg Newsletter*, circulated to Ashland and Mansfield physicians; Microsoft Access programmer — developed a coding and billing software program for solo practice; Turbo Pascal computer programmer — developed a computer-aided instruction program in physiology for Loyola, an interactive program for medical students in the basic science/physiology course.

Family: Married, two children.

Stephen M. Boorstein, MD

Graduated from: University of Michigan Medical School, 1992

Practice location: Toledo

Specialty: Ophthalmology, group practice

Achievements: The George Slocum Resident Research Award (1994, 1995); LaBerge Award for Research in Residency; The Dean's Award for Outstanding Research, University of Michigan Medical School; Stipend Recipient Award, American College of Physicians; Howard Hughes Medical Institute Research Scholar Fellowship, National Institutes



Stephen M. Boorstein, MD

of Health. Clinical associate professor, Medical College of Ohio, Department of Ophthalmology.

Memberships: President-elect of the Northwest Ohio Ophthalmology Society; Ohio Ophthalmological Society; American Academy of Ophthalmology; OSMA; AMA.

Community service: Organizes local ophthalmologists to participate in the nationally-coordinated Mission Cataract USA, where cataract surgery is provided free to needy/indigent patients.

Activities: Coordinates CME for local and regional ophthalmologists as program director of the Northwest Ohio Ophthalmology Society. Also a member of the Academy of Medicine of Toledo and Lucas County's Community Relations Board.

Family: Married.

David C. Packo, MD, FACEP

Graduated from: Ohio State University College of Medicine, 1989

Practice location: Massillon

Specialty: Emergency medicine, board-certified

Achievements: Developed Emergency Medicine Physicians, an equal equity group of emergency physicians that have expanded from three physicians and one hospital to more than 150 physicians at 16 hospitals in four states. Currently serves as president of EMP.



David C. Packo, MD

Career advancements: Assistant director of the emergency department, Massillon Community Hospital in one year; two years later, he was named department director; last year, he was appointed to the board of directors.

Memberships: American College of Emergency Physicians (ACEP); Ohio Chapter, ACEP; OSMA.

Activities: Ohio ACEP Reimbursement, Practice Management and Government Legislative Affairs Committees; member of the ACEP's Chapter Advisory Panel; past counselor, State of Ohio, ACEP annual meeting; Board of Directors, Ohio ACEP; Stark County Medical Society's ADS/Insurance/Medical Business Committees.

Family: Married, two children.

Young physician...

continued from page 14

"The best advice I would give new physicians just entering practice is to become an active participant in the formation of future medical policy and structure. We can no longer be passive observers in the political process that will decide our future practice guidelines and reimbursement procedures. We as physicians have to assume a leadership role to assure the appropriate care of our patients and the independence to practice medicine as we so desire." — **Ronald M. Yarab, Jr., MD**

Ronald M. Yarab, Jr., MD

Graduated from:
Medical University of South
Carolina, 1989

Practice location:
Youngstown

Specialty:
Physical
Medicine and
Rehabilitation,
board-certified.



Ronald M. Yarab, Jr.,
MD

Career advancements: Medical director, Austin Woods Sub-Acute Rehabilitation, Austintown; medical director, CRA Managed Care, Inc.; regional medical director, CareWorks of Ohio, Inc.; regional medical director, Parman and Associates; Medical consultant, Ohio Bureau of Workers' Compensation; CARD surveyor; associate clinical professor, Department of Physical Medicine, Ohio State University.

Memberships: American Academy of Physical Medicine and Rehabilitation; American Congress of Rehabilitation Medicine; Physiatric Association of Spine, Sports and Occupational Rehabilitation; OSMA.

Activities: Member of the Mahoning County Medical Society Council; chairperson, MCMS Young Physicians Committee; executive committee member, Republican party.

Family: Married.

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On the Web...

Looking for CME? Check out the Web

If you need some additional hours of CME and don't know where to find them, check out the OSMA Web site at www.osma.org.

Currently, there are about 75 listings of opportunities available for physicians. This number changes daily.

Also in this section you'll find the names of 71 accredited sponsors.

For those who have never visited the CME section. Here's what you'll find:

- This is a protected area, meaning you must be an OSMA member to enter this section.
- After clicking on CME, you'll be asked for your 11-digit ME number.
- The first few pages list the 71 accredited sponsors. At any time while perusing the accredited sponsor list, you can click on "Go to the Continuing Medical Education Schedule."
- You can search for a particular educational program by location, date or activity or simply browse all the records to see all the options.
- Select your preference for searching and then fill out the field box.
- Once you call up a particular activity, you'll be given the number of CME hours available, location, time, place, cost, and contact for more information and registration.

We discussed the CME section with a number of physicians prior to designing the site to determine how they select courses. What we found, was that the numbers were divided among location, date eligibility with the physician's schedule, and subject material.

Some of you may have received a survey from the OSMA Committee on Education asking about your CME needs. For results of that survey and more CME information see the stories on page 9 of this issue. ■

Take Action

If you have comments or suggestions for the OSMA Web site e-mail: Karen Kirk at kkirk@osma.org.

OSMA happenings...

• **Managed care task force provides input on PHPPA implementation...**At a recent meeting of the OSMA's Task Force on Managed Care, members provided input on several key issues regarding implementation of the OSMA-Kaiser Permanente's Physician-Health Plan Partnership Act. Among the topics discussed were: how to authenticate prior approvals; how will standing referrals work; physician obligation under UR programs; and certification of nonformulary drugs. OSMA Division of Legal Affairs is working with the plans on these and other implementation issues. Task force members also discussed the ethics of an unusual arrangement, where a small group of Ohio physicians allowed nurses to provide coverage for them when the physicians were unavailable. The group has since withdrawn this arrangement, but task force members discussed whether or not nurse-coverage may be a future trend.

• **Group Practice Section eliminates participation fee...**Group practices that want to participate in the OSMA Group Practice Section (GPS) will no longer have to pay a participation fee. Council voted in November to eliminate the fee at the recommendation of the GPS Governance Committee, which said the fee hindered the section's growth. Originally, the GPS Marketing Task Force developed the participation fee as an alternative to an OSMA dues discount program for section-member groups. The fee was structured to encourage group participation in the section, as well as the retention of individual OSMA-member physicians within participating groups. The fee was waived if 90-100% of the group's physicians were OSMA members. Susan Rupli, director of Group Practice Services, says in its 20 months of existence, the section has received no requests for memberships from groups that would have to pay the additional fee. "Groups of all sizes with significant OSMA membership, especially those anticipating future growth, will be served in some manner by OSMA staff," says Rupli. The participation fee, however, proved off-putting to some groups. "By dropping this fee, it's likely that membership in the section will increase," says Rupli.

• **Seminar prepares physicians for fraud and abuse investigations...**What you don't know about fraud and abuse laws can hurt you, as new federal statutes now make physicians criminally liable for fraud and abuse activities. The OSMA and Columbus-based law firm Porter, Wright, Morris and Arthur, joint-sponsored a seminar last month that told participants how the laws are enforced in Ohio; what specific prohibitions apply to their practices; and how physicians can be indirectly trapped by these laws. The seminar is an example of the educational opportunities the OSMA makes available to you as an accrediting body for continuing medical education. (See related story on page 9.)

• **DNR rules due soon...**The OSMA's DNR (Do-Not-Resuscitate) Advisory Committee is in the final process of finalizing/approving new DNR rules for Ohio. Once the rules have been completed, the OSMA will begin to educate physicians about the new law. Watch *Ohio Medicine* as well as the OSMA's Web site, www.osma.org, for information about the DNR law.

• **OSMA physician chats live online...**Andrew Thomas, MD, resident member of the AMA's Board of Trustees, (see his AMA report on page 13) participated in a live online discussion on the *Wall Street Journal's* "Interactive Edition" in late October. Among topics discussed in the WSJ "chat room" were the future of Medicare, rising health-care costs, the use of the Internet in medicine, rationing care, elder abuse, the scopes of allied practitioners, alternative medicine, managed care and medicine/business. The transcript has been archived, but is accessible only to members of WSJ. ■

We need to be our patient's info source

It has sometimes been called the "silent thief" because it can progress without symptoms or pain.

Then, one day, women — who didn't even know they were at risk — break a wrist, a hip, their spine or some other bone.

I'm speaking of osteoporosis, of course, a disease that is becoming more and more prevalent as Ohioans grow older. Nationally, osteoporosis affects between seven and eight million individuals — and 17 million more suffer from low bone mass.

Osteoporosis is not entirely a women's disease. Men can suffer from it as well. But women are four times more likely to develop the disease because they have lower bone mass than men, and they lose that bone mass at a greater rate, especially at menopause. In fact, half of all women over the age of 50 years are affected with osteoporosis. It is a preventable and treatable disease with early counseling — even in teen-agers.

In a previous column, I mentioned that, as OSMA president, I have adopted two educational initiatives this year. One of these I discussed in October — domestic violence. My second initiative is to increase Ohio physicians' awareness of osteoporosis, and of our need to talk to female patients about this debilitating disease. Do you know which of your patients are at risk? Have you discussed with them steps they can take to prevent osteoporosis?

In May — the official "Osteoporosis Awareness" month — the OSMA will launch its first-ever osteoporosis educational campaign. In addition to educating you about the importance of talking to your patients about osteoporosis, the campaign is also designed to emphasize the importance of osteoporosis screening. The most effective way to screen for osteoporosis is through a Bone Mineral Density (BMD) test. A



Lance Talmage, MD

President's Perspectives

BMD test detects osteoporosis before a fracture occurs. (Standard X-rays fail to diagnose the disease until about 30% of the bone is already lost.) Screening should be done on all women who have reached menopause and earlier in men and women who have predisposing conditions and treatments.

As an additional benefit for OSMA members, the educational materials that will be developed and distributed will be available for continuing medical education credit.

The osteoporosis campaign will have a patient education component as well. Information about identifying and preventing osteoporosis will be sent to you, and you in turn, can distribute this information to your patients. White lace ribbons, the national symbol for osteoporosis awareness, will also be sent for wearing and distributing in your office.

When it comes to public health issues, like osteoporosis and domestic violence, we need to identify ourselves as key players. We need to keep our patients informed about what is best for their health. Our role as patient advocates make this a natural fit.

I hope, in the coming year, you'll make some time in your practice to discuss both domestic violence and osteoporosis with your patients. They need to know that you are the best source for this information. With the OSMA material that will be made available to you on both of these topics next year — you will be even better prepared.

Happy holidays to all of you. ■

Practice Tips

Should your practice develop its own Web site?

To Web...or not to Web? That is the question many computer-savvy physicians are asking these days. Is now the time for you to develop your own medical-practice Web site on the Internet?

That depends. First, look at your patient demographics. Younger patients are more inclined to use the Web – but don't underestimate the senior population. More and more of them are becoming computer literate, and are becoming active Internet browsers. Women, too, are jumping online in increasing numbers. According to Nielsen Media Research and Commerce Net, 43% of Internet users are women – and women are typically the family's chief decision-maker when it comes to professional services of any kind.

If your current patient base is comprised of any of these groups, then an online presence may not be a bad idea. It's an even better idea if you hope to attract members of these groups to your practice as prospective patients. In the world of marketing, the simple fact is, a Web site will give your practice exposure to an audience it may not have been able to capture before.

If you're one of those physicians who still shudders at the thought of "marketing" their practice, consider this: As Congress and the state legislature continue to address access issues – through point-of-service plans, medical savings accounts, etc. – patients are assuming more responsibility in choosing their physicians than in the past, and even those in managed care frequently have a "choice" of providers. A Web site will make your practice more competitive if you're looking to expand your patient base.

OK. You've decided a Web site is a

good idea. Now what?

Creating a Web site

Just how dynamic and appealing a site is will depend on your own artistic and technical skills, as well as the time you and/or your staff have available for initial design and regular updating. Free, basic Web sites are available to America Online subscribers, or you could check out low-cost (less than \$200) design packages available off-the-shelf, such as FrontPage and Adobe PageMill.

If you do it yourself, keep the following tips in mind:

- Keep individual page downloading time below eight seconds.

- Place contact phone numbers on every page.

- Establish a "master" look by maintaining a few key elements and colors throughout the site.

If you have more money to spend (\$600-\$1,000+), hire a Web site designer with experience and a higher-end technical platform for a more polished, cohesive look, and more interactive options.

Before you hire, however, call around for a number of bids. The field is so new that prices for Web site design are all over the board. Karen Kirk, ODMA Web site coordinator, says bids for the ODMA Web site design fluctuated by thousands of dollars, so don't stop with the first, or even third bid you receive. Keep calling until you find a price you're comfortable with.

Then, check out sites that this designer has produced – for pay. (Pro bono sites are not typical because the designer usually has creative freedom, and few budget constraints.)

Other considerations before choos-

ing a designer:

- Will he/she work with you to design something appropriate for your personal style and type of practice?

- How is the proposal structured? If it's submitted as a lump-sum, ask to see a break-down of the different project elements.

- Is any form of Internet marketing included, like linking your site with other logical sites?

- Will the designer help you write your visible and hidden key word descriptions so that people can find you?

- Will there be a monthly hosting cost (to someone with a server) and updating costs (unless you or your staff intend to update the site yourself)?

Don't forget, if you hire someone to design special software for your site, they own the copyright unless you negotiate otherwise.

What goes on a Web site?

When you're devising any marketing strategy, think first of your current patients. Your site should contain material that will reinforce and strengthen your existing relationship with them. Keep them informed of any news from your practice, health-care articles, and links to relevant sites. If you're soliciting subjects for a test study, the Web can be a useful recruitment tool.

By making your site fresh and appealing, you're likely to attract new patients as well. The more that browsers visit your site, the more it reinforces your practice as a valuable resource in their lives. – Carol Larimer

Next month's issue will tell you how to measure your site's effectiveness and if Web sites are ethical.

Yellow pages: Low-tech marketing

You've decided not to build a Web site – for whatever reason – but you still want to market your practice. In that case, turn to the Yellow Pages, a low-tech workhorse that may still give you the greatest bang for your promotional buck. For cost per impression, at least a one-year shelf life, and good average frequency, it's hard to beat the value of an ad in the best-circulated Yellow Pages book in your area. (Since many cities now have more than one Yellow Pages, ask for circulation figures before you decide where to place your ad.)

Studies have shown that 21% of consumers use the Yellow Pages to choose their physician, and consider this: Many individuals consider the Yellow Pages to be more of a community data bank than a collection of ads – so, in the mind of the public, if a physician is not listed, there may be a question about that doctor's credibility. That's why a listing may be a good idea – whether you are on the Internet or not.

When designing or approving your ad (if it's done by an outside agency), remember to include all the basics that consumers look for: Specialty, location, phone number, office hours, years of experience and professional credentials. Here are some other tips to producing an effective Yellow Pages Ad:

- Choose a distinctive type face, add a logo and a clean arrangement of type. This will visually communicate style, substance, quality and value.

- Consider multiple listings, under specialty and even subspecialty heads, if they apply. A key part of any advertising effort is multiple exposure.

- Avoid medical illustrations unless it is very clear what they represent. To many members of

continued on page 21

Y2K preparedness

Medicare urges tests on dates

In order to avoid as many year-2000 (Y2K) submissions problems as possible, Medicare is encouraging paper claims (HCFA 1500) providers to consistently use eight digits (MM DD CCYY) for birth dates and is offering tests of dates on claims submitted electronically.

The previously announced date (Oct. 1, 1998) for use of eight-digit birth dates on paper claims has been postponed. At the present time, the carrier will not be returning a paper claim because it does not have the eight-digit birth date on it. The carrier, however, is required to make the conversion before passing the information into their entry system. Physicians and providers should make every effort to follow this, and all instructions, which will assist smooth processing and earliest possible payment.

Some physicians are still on a paper system, and paper will remain an important back-up for electronic claims.

For physicians filing electronically, both National Standard Format (NSF) and American National Standards Institute (ANSI) 837 formats require eight-digit date fields.

Medicare electronic-claims providers are also encouraged to take advantage of the Nationwide-Medicare offer to test 15 specific dates compiled by HCFA. Letters making the offer were sent in September to all medical offices and others who bill for Medicare services electronically. The process is simple and effective for testing all date fields that an office uses, in both NSF and ANSI 837 formats.

The testing will provide the provider with a listing of the dates created by his or her software. These are the dates that would be used for processing by Nationwide-Medicare's adjudication system if the file were submitted as production.

Checking your system now may help prevent any reimbursement delays from Medicare in the year 2000. —

Carol Larimer

OSMA Insurance Agency

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A "to do" list for retiring physicians

If you're planning on retiring from practice soon, then you should be making retirement plans now. The earlier you start planning your retirement, the more time you'll have to work with attorneys, accountants and others who can help you close your practice.

The following is a simple "to do" list for physicians who are considering retirement within the next year or two (you should begin your retirement plans at least one year out.) It is compiled from the OSMAs legal fact sheet on "Retirement." See "Take Action" for information on how to obtain the complete fact sheet.

To do:

☐ Terminate the physician-patient relationship.

- Notify all patients that you are retiring. Let them know of your intent to withdraw care by a definite date, allowing sufficient time for the patient to obtain alternative care.

- At a minimum, notify all active patients by certified mail. Usually, active patients are those seen within the past two years, but if you have a question as to whether or not a patient is active, consider that person an active patient for notification purposes.

- Consider running an advertisement in the local paper announcing your retirement. This will help notify your inactive patients as well.

- A three-month notice is usually sufficient.

☐ Notify your employees.

- Notify your employees at least three months in advance of your retirement date to allow them time to look for other jobs or to plan their future.

- Notify insurance companies, if you insure your employees. And remember, state and federal law requires that employees be offered the option of continuing health insurance either under an individual policy or continuing under the group policy for a period of time.

- If you offer a pension or a profit-sharing plan to employees, you'll need to contact an employee benefits advisor to help assist you with the complex issues and requirements in this area.

☐ Arrange to retain your medical records

- You'll want to maintain and retain your medical records at least until the statute of limitations for any potential malpractice claim has expired. However, because the statute of limitations for malpractice claims is so broad, the OSMAs recommends you keep your original medical records for an indefinite period of time. This period can usually end at least two years after the death of a patient or the death of the physician. With regard to the latter, the AMA Council on Ethical and Judicial Affairs states it is better to transfer the patient records of a deceased physician to another physician rather than destroy them.

- If you choose to discard your records, destroy them completely, in a manner that preserves patient confidentiality, such as shredding.

- Third-party payor contracts often specify the length of time that participating physicians must retain their medical records. Be sure you check your contract for this information.

- Always keep the original records, unless you are transferring them to a custodian. If you are transferring records to a patient or another physician, you should dictate, summarize or photocopy the medical record instead of transferring the original.

☐ Dispose of drugs, notify the DEA

- If you do not intend to maintain your medical license, or actively practice, you must terminate your DEA registration by mailing your DEA certificate and any unexecuted order forms to the DEA office.

- Any controlled substances on hand should be returned, transferred or disposed. If you dispose of controlled substances, send a list specifying the

name and quantity of controlled substances to be disposed to either the Ohio Board of Pharmacy or the DEA district office, whichever serves your area. You will be given authorization and instructions on how to dispose of the controlled substances.

- Keep the final inventory of all controlled substances and any copies of DEA order forms for at least two years following your retirement.

☐ Decide whether or not you will keep your medical license.

- You are not required by law to notify the State Medical Board of Ohio of your retirement. However, if you wish to maintain your medical license, you must still continue to complete 100 hours of continuing medical education every two years.

- If you choose to surrender your license or allow it to expire, you may

not provide unsupervised medical services – including volunteer work. ■

Take Action

The OSMAs Legal Fact Sheet on "Retirement" includes additional information on such items as: retirement and professional organizations, social security, professional liability insurance companies, office insurance and winding down your practice. To order a copy of the fact sheet, contact the Ohio Medicine reader response line, (800) 766-6762, Ext. 6580, and ask for Item #37-98. Or you can check out the fact sheet on the OSMAs Web site, www.osmo.org. You'll find it under "Hot News." Scroll down through the Hot News items until you reach "Legal Fact Sheets." Click on "Retirement."

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Yellow Pages...

continued from page 18

the public, these illustrations are a lot like ink blots. They can read a lot of images into a picture they don't really understand.

- Use the color red in your ad tastefully. It can scream, "I'm hungry for patients!" so consult a designer before choosing red.

Most marketing experts agree that, for physicians, a listing in the Yellow Pages is simply a part of the cost of doing business. Through its pages, physicians can get into virtually every home in their community — and, at least so far, even the Internet can't promise that. ■

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GARY BIRNBAUM, MD, JD, Mayfield Heights, has been appointed to the Adjunct Faculty, Case Western University School of Law and is teaching a course entitled "Health-Care Professions."

ROBIN COTTON, MD, Cincinnati, director of otolaryngology and maxillofacial surgery at Children's Hospital Medical Center of Cincinnati, has been named acting surgeon-in-chief at Cincinnati Children's. Dr. Cotton was praised for his sincere interest in assisting in the medical center's mission to be the leader in improving child health.

FRED A. ELKUS, MD, Cincinnati, has been named physician director for business development at Drake Center. Dr. Elkus has 45 years' experience as a clinical and administrative physician. He has been medical director for long-term care at Drake Center for the last seven years.

Colleagues

MARY BETH HALL, MD, Newark, has been named Physician of the Year by her professional colleagues at a reception hosted by Licking Memorial Hospital in October.

SIMON KOVALIK, MD, Toledo, was recently named president-elect of The Toledo Surgical Society.

KENNETH A. KROPP, MD, FACS, received the 1998 Award of Distinction given by the Toledo Surgical Society.

LAWRENCE KURTZMAN, MD, Cincinnati, and his supporters want to anchor their efforts in Cincinnati with the hope of launching a local affiliate of Operation Smile, the nonprofit relief organization

founded in 1982 by his former professor, Dr. William Magee of Eastern Virginia Medical School. The target of all their efforts is the common birth defect known as cleft lip, or the related malady, cleft palate. Nothing is sweeter or more potent than a smile, it's the greatest form of diplomacy to give a kid a smile, said the 40-year-old plastic surgeon from Cincinnati.

HOWARD S. MADIGAN, MD, FACS, Sylvania, recently became president of The Toledo Surgical Society.

MICHAEL NUSSBAUM, MD, Cincinnati, chapter medical advisory committee member, and Mercy Health Partners was honored for the Crohn's & Colitis Foundation of America Inc. The tribute generated more than \$32,000 for CCFA, which supports research to find a cure for Crohn's disease and ulcerative colitis, and provides educational and support services.

Obituaries

ROBERT BARRETT BIRD, MD, Canton, University of Illinois at Chicago Health Sciences Center, Chicago, 1952; age 73; died Sept. 30, 1998.

ROBERT J. DEGER, MD, Dayton, St. Louis University School of Medicine, St. Louis, 1936; age 85; died Oct. 10, 1998.

SAMUEL D. GOLDBERG, MD, Youngstown, Wayne State University School of Medicine, Mich., 1936; age 87; died Oct. 14, 1998.

FRANK L. MAULER, MD, Florida, Ohio State University College of Medicine, Columbus, OH, 1943; age 79; died Oct. 12, 1998.

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